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# Excellence within the Navy health care system

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# NAVAL POSTGRADUATE SCHOOL
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# THESIS

EXCELLENCE WITHIN THE
NAVY HEALTH CARE SYSTEM

by

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December 1984

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David R. Whipple

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This project was approached by identifying Naval Hospitals that should be studied, based on subjective opinions of eighteen senior Naval Medical Department officers. After soliciting the senior officer's views on hospital excellence

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the next step was to ask them to identify hospitals that personify excellence as they had described it. Base on these lists, visits were made to the three commands most often acknowledged as being excellent. This study then outlines those indicators of excellence that such commands emphasize which have made them the best that we have to offer. From these findings, recommendations are made regarding the usefulness of this study in the Navy Medical Department.

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# Excellence within the Navy Health Care System

by

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requirements for the degree of

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December 1984

## ABSTRACT

The purpose of this study was to find Naval Hospitals that were the embodiment of superior performance and to then tell their stories - what they look like, what they emphasize, and why they manage and lead the way they do.

This project was approached by identifying Naval Hospitals that should be studied, based on subjective opinions of eighteen senior Naval Medical Department Officers.

After soliciting the senior officer's views on hospital excellence, the next step was to ask them to identify hospitals that personify excellence as they had described it. Based on these lists, visits were made to the three commands most often acknowledged as being excellent. This study then outlines those indicators of excellence that such commands emphasize which have made them the best that we have to offer. From these findings, recommendations are made regarding the usefulness of this study in the Navy Medical Department.

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# I. INTRODUCTION

Have you ever wondered just what makes a hospital excellent or effective? Throughout my fifteen years in the Navy I have. What would an excellent Navy hospital really look like? Just what are the criteria that the executive level of the Naval Medical Department use to differentiate between hospitals and to evaluate the Commanding Officers' of those hospitals? What is discussed within the passageways of the old Naval Observatory which would give an officer an idea of what is truly excellent and what is average? Answers to these questions are what I sought. I wanted to go into the passageways and offices of our executive leadership to find out what they were saying, thinking, and feeling. What are the objective and subjective criteria that they, our executive leadership, use to rate the performance of individual hospitals?

But before attempting such an endeavor, I also wanted to search the literature. The seemingly endless literature. While hundreds of studies have been conducted both in the civilian health care delivery system and our Naval health care system, they have often been limited conceptualizations on the subject of excellence: studies breaking health care delivery down into "simple" component parts, thus avoiding the complete analysis of the entire subject; many studies and surveys which tell us how to assess patient satisfaction; reports which deal with aspects of admission procedures, medical personnel education and training, public relations, manpower supply and requirements, quality assurance, uniform staffing methodologies, and uniform chart of accounts to name just a few. Although these studies are useful to military health care systems, it is very difficult

to put together the results of these fragmented studies to give a true picture of excellence in health care.

The Naval health care delivery system's problem is further complicated. Unlike the civilian health care system, the Navy has a fixed, defined patient population which limits such studies' comparability. For example, Thomas E. Getzen [Ref. 1], states that "the actions in the marketplace provide a valid informal evaluation of quality. Patients choose from the available providers, the one they expect to meet their needs the best." Thus, "the ultimate test of quality in the marketplace continues to be its acceptance by patients, and hence the decisive forms of quality evaluation and control are the choices made by the patients acting as consumers." As he points out, one of the measurements then, in the civilian health care arena, is the fact that increased quality will provide greater profits. This just does not hold true in our military medical system. Another important aspect that seperates the Navy health care delivery system from our civilian counterpart is our dual mission. As in the civilian health care delivery system, we must be concerned with beneficiary health care. But we must accomplish this complex task in addition to our primary reason for existance, contingency for war. However, despite these difficulties, the real need does exist to develop a methodology for assessing excellence in the Navy health care system; to bring all these fragmented studies together into one clear picture. This paper is an attempt at accomplishing that; to describe excellence within the Navy health care delivery system.

To search out this vision of excellence, I choose to go to our executive leadership, the leaders of our Naval Medical Department, who have been intimately involved with Naval Health Care. My intention was to learn from their experience, to gain their insights and to gather their

opinions of hospitals and health care facilities that they felt came closest to the vision of excellence that they had described. These visions were different from leader to leader, but overall, they painted a vivid and breath taking picture of true excellence.

My next step was to visit these facilities that our leadership had described. My mind was filled with excitement and wonder as I undertook this monumental task that took me to the four corners of the Continental United States. Questions plagued me. Do we really have Navy health care facilities out there somewhere that meet the standards of excellence described? Altogether, our medical leadership had given me over nine facilities as nominees. Obviously, this list had to be narrowed down. As a consensus, there were only three facilities that all the leadership agreed came closest to being excellent. There did not seem to be a consensus that we indeed had excellent hospitals as they had defined it. However, I did visit the three that came closest. Their stories are what I intend to share with you. I will not disclose names of people or commands that I visited. Due to the confidentiality needed to complete the study, I will just share with you the stories and comments of the personnel I interviewed.

In the first few chapters, I will sketch and explain my methodology for approaching this challenging task. I will take you to the halls of the old Naval Observatory and let you read the indicators of excellence that over eighteen of our executive leaders have identified. In the remaining chapters, I will summarize the stories and comments of over one hundred personnel within the three hospitals that I visited. I will attempt to answer the questions of what they are doing that sets them apart, or let you determine if they really meet the standards of excellence that were identified. Finally, I will share with you my conclusions and recommendations from this study of excellence.

## II. METHODOLOGY

To plan and organize this thesis project, it became readily apparent that a clear methodology had to be developed. Research into the many models of organization theory provided insights, but all seemed to be focused on specific, measureable attributes of organizations; traditionally strategy and structural components. I felt that this traditional view left out many other aspects of organizations that needed to be clarified if indeed, a meaningful effort was to be attempted at clarifying excellence within the Navy health care facilities.

As my search continued for an appropriate methodology, an answer to the dilemma seemed to present itself. In researching In Search of Excellence, Peters and Waterman [Ref. 2]. struggled with the same dilemma. They found that "any intelligent approach to organizing, had to encompass, and treat as interdependent, at least seven variables: structure, strategy, people, management style, systems and procedures, guiding concepts and shared values (i.e., culture), and the present and hoped-for organization strengths or skills." With further clarification and refinement, they made all seven variables begin with the letter S and thus developed the McKinsey Seven S Model. The model has caught on and has been utilized as the foundation of other research that has been recently completed including The Art of Japanese Management by Richard Pascale [Ref. 3].

The McKinsey Seven S Model, as depicted in Figure 2.1, assisted me, not only in focusing my attention at the usual hardware of structure and strategy, but also about the intangible aspects of organizations - style, systems, staff, skills, and shared values.

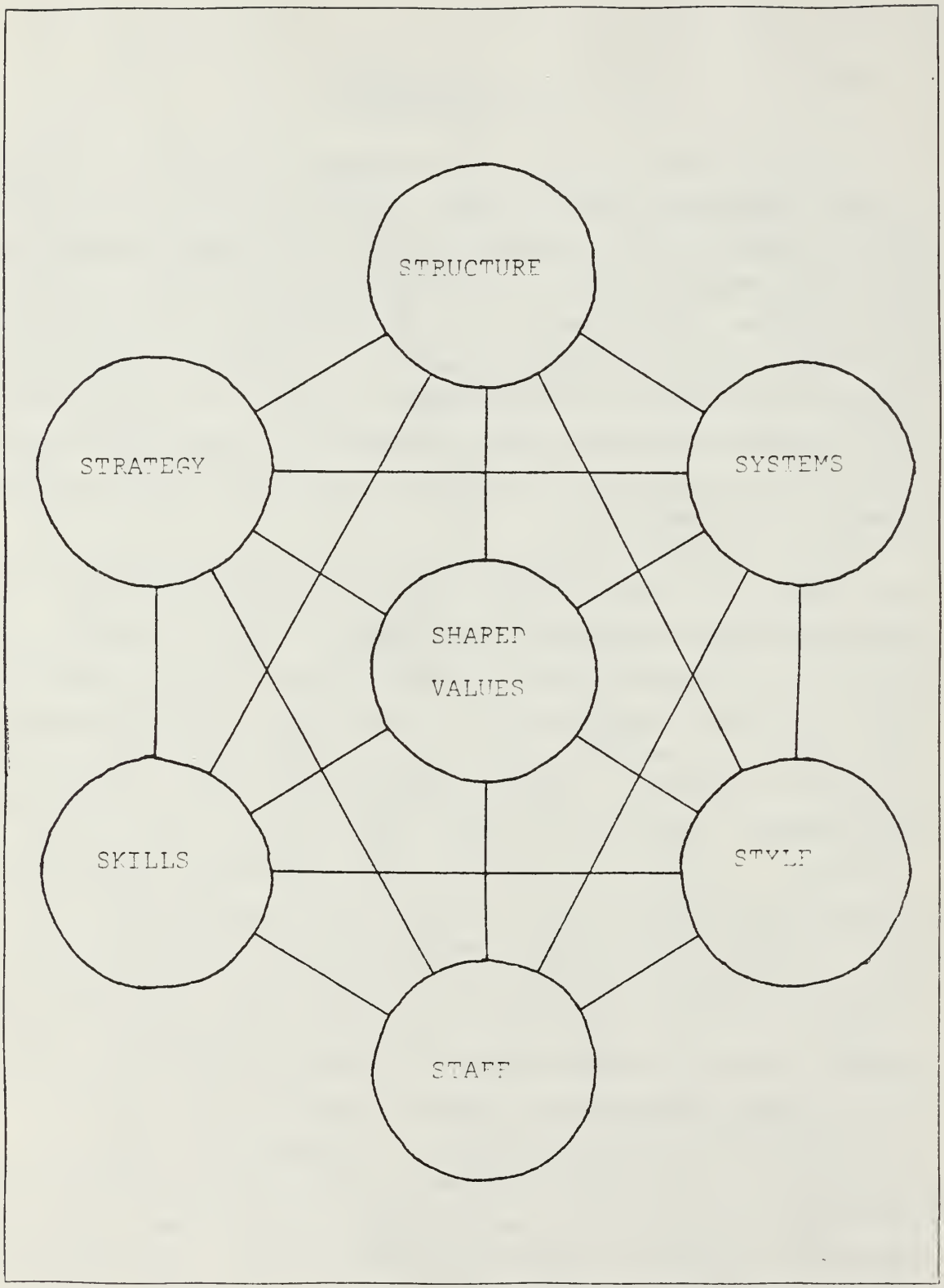



Figure 2.1 The McKinsey 7 S Model.

All medical department leaders are aware of the fact that it takes much more than meeting specified production goals within a given budget to have an effective and excellent command. This model seems to lend credence to their beliefs, and allows a researcher a methodology for analyzing excellence. However, to utilize this model effectively, it was necessary for me to further define and slightly modify each of the seven variables so that each could be assessed and measured. Further clarification and definition of each variable is as follows:

1. STYLE: The behavior of people and the process by which they interact. Leadership style and management style. Norms of authority and influence. This style of leadership and management is the means by which potential energy and motivation are converted into results.
2. SKILLS: Talents and experience of key personnel, both officer and enlisted.
3. STRATEGY: A plan of action designed to assist a command in moving from where its policies and practices are now, to how they would like to function in the future.
4. SHARED VALUES: Intangibles such as the general impression of personnel, command values, norms, and guiding concepts of the organization. An organization ideology which provides an important organizational theme and belief for behavior of its personnel. Feelings by personnel that the hospital is effective. Commitment to the hospital by its personnel.
5. SYSTEMS: How objectively and faithfully information is shared and represented within a command.
6. STRUCTURE: Characteristics of the organizational chart. Who reports to whom? How various departments work together. The differentiation and reintegration of the various departments and work centers.

7. STAFF: Professional background of officer and enlisted personnel on the staff. Their values, beliefs, skills, and job experience.

These seven variables provided the focus for the development of semi-structured interviews with the executive leadership of the Navy Medical Department and for each individual hospital that I visited.

## III. EXECUTIVE LEADERSHIP'S VIEWS

I was extremely excited as I set about the task of interviewing the Naval Medical Command's executive leadership. I was anxious. After all, how often does a junior officer have an opportunity to listen to the views and opinions of flag officers on the topic of excellence. My excitement continued to build as I prepared to visit my first senior officer. I wondered about his views of excellence and the types of variables he would describe. Would all the senior officers within the Navy's medical community have the same vision? With all these questions lingering in the back of my mind, I started the endeavor. After two months and eighteen interviews with the executive leadership, I had completed the task. I had gathered over two-hundred typed pages of information from Commanders to Vice Admirals, each of whom had met my prerequisites regarding rank and post-command experience.

It is within this chapter that I intend to share with you our leader's views, comments, and beliefs regarding excellence in Navy health care. I will attempt to draw a picture of excellence from their comments. It is my belief that this "picture" is the closest that we in the medical community have achieved in defining this vision. In fact, I could find no current documentation of any kind that detailed "excellence" in Navy medicine. As I talked to each of the senior officers in my search for excellence, it became apparent that they view organizations from three distinct perspectives/viewpoints. In order to paint this "picture" that they shared with me, I will address each of these viewpoints separately. The picture of excellence should become clearer as we progress through each perspective that I will describe.

The first of the three of these perspectives will be entitled "Quarterdeck indicators" of excellence. The second and third are entitled "Indicators from the Office of the Executive Leadership" and "Internal Functions of an Excellent Command" respectively.

## A. QUARTERDECK INDICATORS

The first of the three perspectives is the Quarterdeck Indicators. These include those variables that our executive leadership have stated they observe when they first arrive at a facility. They embrace the all important first impressions that we intuitively arrive at when visiting a command. Lets take a look at what our leadership feels is important when they visit a command.

### 1. Cleanliness is Next to Godliness

Oh yes, the age old story of cleanliness has raised its head again. But is it really an indicator of excellence? Our leaders think so, and with good reason. The one point that every flag officer mentioned, without exception, was the fact that the excellent hospital would be a clean hospital. The grounds would be groomed and manicured. The passageways and clinics would be scrubbed and polished. There wouldn't be any trash on the floors. The staff would have pride in the facility. In fact, if a command member saw a piece of paper on the floor, he/she would stop, pick it up, and throw it away.

I can't emphasize the importance that the officers I interviewed placed upon cleanliness. As one executive said; "That first impression is so powerful, that it really behoves us to take advantage of it." However, without exception, each officer was careful to point out that the manner in which the cleanliness of the facility is

accomplished or achieved is the key to its success. One senior officer put it nicely. "I can ensure that a hospital is kept clean through an autocratic leadership style and through micro-management. However, if I truely want a hospital that is clean and well maintained, then I have to instill that value throughout my staff and the community we serve." Another senior officer said he could identify how well a hospital is functioning by just walking through the passageways of the command and observing the personnel's uniforms, grooming standards, and their attitudes towards him. To him, these attributes said it all. It was this same senior officer who said; "if personnel have pride in their command and in their mission, it will, without any doubt, show in the appearance of the facility, their appearance, and in the attitudes that they exhibit." Another officer commented that it was not just keeping the facility clean, but going beyond that point. Is the grass around the hospital mowed, or is it well manicured? Are the passageways clean, or are the bulkheads and britework cleaned and shined?

Another officer put everything into a nutshell. "If the grounds and hospital are clean and well groomed, it presents a halo effect around the command. No matter what kind of attitude a staff member or patient is in when they leave home, the very sight of the hospital presents an uplifting and positive event for them." The patients and staff look forward to coming into the hospital. So, is cleanliness really an indicator of excellence? I think so, and so do our leaders.

The key seemed to lie within the "hows" and for what reasons an excellent hospital was a clean hospital. Our leadership felt that it is driven by a common value system within the organization, a pride not only within the command, but also within the patients we serve. That's what

drove the cleanliness. Not the autocratic "you do it or else" approach we all have experienced in our careers. Current literature supports this view. Peters and Waterman discussed this same point. In their chapter entitled "Simltaneous Loose-Tight Properties", they alluded to an organization's values and culture. It is this value system, established from the leadership of the hospital, that seems to be the driving factor to any organization's success. It is this very same value system that our leadership was addressing when they made the comments that it is "how" the cleanliness is maintained that's important. So, yes, cleanliness is a mark of excellence in the eyes of our leaders. Maybe cleanliness really is next to godliness.

2. Our Attitude is a Key

The attitude displayed by the hospital staff was considered to be an important indicator of excellence by our executive leadership. Not only the attitude of the staff, but also the attitude of the patients. One of our senior officers stated that when he visits a facility, he makes an effort to ask questions of the staff and observes their behavior. He also walks through the Outpatient Department and observes the expression on the face of the patients waiting to be seen. "I can always tell the difference between a sick patient and a sick and disgusted patient", as one of our senior officers put it.

In an excellent command, all personnel, from the commanding officer to the most junior member, would have a positive outlook on themselves and the hospital. All personnel would have a common belief that what they were doing was important and really made a difference. There is a common belief that this is my hospital and that the patient comes first. In an excellent hospital the most important management fundamental that seems to be ignored not only

within Navy Medicine but by the business world in general, is staying close to the patient and clientele we serve; anticipating and satisfying their desires and wants. Peters and Waterman also found this as a major attribute of excellence in the business world [Ref. 4]. They wrote:

> "In observing the excellent companies, and specifically the way they interact with customers, what we found most striking was the consistent presence of obsession for service to customers and gratification of their desires."

Our Commander, Naval Medical Command alluded to this same attribute in a recent Navy Medicine article [Ref. 5]. In it, he addressed the issue of why beneficiaries feel we give less then quality medical care.

> "It's not that the actual treatment is not good; it's simply that some of our beneficiaries perceive the treatment is not good. We can negate some of those impressions with good old bedside manner. This bedside manner starts the minute our patients walk in the door and continues until they leave. It's based upon cheerful smiles and personal attention that go hand-in-hand with actual medical treatment. It has to do with sharp uniforms and military bearing. It means going out of the way to be helpful to our patients. It means taking the personal initiative to make sure things get done right - not using the cliche "it's not my job". It means taking time to explain to patients what's going on, making sure they understand and accept what your saying."

These are the attitudes exhibited in the behavior of personnel that our leadership says would be present in an excellent hospital. They all made comments to this aspect of excellence. One of our senior officers stated; "it's seeing a patient in the passageway who appears to be lost, and asking them if they need help; then escorting them to the area they are searching for." It's simple, it's the reason most of us joined the medical profession, to serve the patient. Yet, with the high tempo of operations, and our day-to-day struggles, most of us have forgotten this aspect of the business.

In an excellent hospital, you will find a reaffirmation of those beliefs. After all, no matter how good our medical care is, if it is not perceived to be excellent, then we've forgotten something in the process. Rear Admiral McDermott has addressed this issue in many of his "Notes from the Commander" articles. Our leadership has made it clear that an excellent hospital will have met the challenge and overcome the environment in our treatment facilities that can be sterile, dehumanizing, and frightening. Our attitudes, and thus behaviors towards the patients we serve, show in the reception they receive at the information desk, from the staff members in the passageways and elevators who have reaffirmed that a great deal of quality medicine is a smile and a kind word, a gentle word of explanation, and a sincere desire to serve the patient. This, as our leadership has so aptly pointed out, is indeed an important variable of excellence.

## B. INDICATORS FROM THE OFFICE OF THE EXECUTIVE LEADERSHIP

These are the indicators that our executive leadership view from their desks at the old Naval Observatory. They're the factors that they see most often. They include all the paperwork and reports that are generated by each command to the Commander, Naval Medical Command. From this immense input of data, which do our senior officers put the greatest importance on when examining excellence? This section will attempt to answer that question along with the rational for their particular selection.

Without fail, every officer interviewed placed a strong emphasis upon how well it appears a navy hospital is executing their budget. Are they on target, under target, or operating above their means? For what are they spending their dollars, and is there a strong justification for their

emphasis? It was very clear that the financial reports and the execution of the budget were important to our executive leadership. But why? What does it really tell them about how well a hospital is functioning? It can indicate how well resources are being used. As one senior officer put it, "the budget is a plan of action expressed in figures which usually has a budget variance, the difference between what was actually incurred and the budget figure. If the variance is positive, it tells me that the command was effective in executing its' plan of action. If it is a negative variance, then they had problems." All agreed that the budget is used as an indicator, and only as that.

Our senior officers generally feel that our healthcare delivery system is managed by Medical Department Officers who possess high professional skills and who exhibit a wide range of personal values. Yet, as they also pointed out, to achieve the goals of the Navy Medical Department, they must also observe and be guided by the "budgetary imperative". Captain Morin, in a recent U.S. Navy Medicine Article [Ref. 6], stated that the budgetary imperative is based upon two assumptions and three rules. The assumptions are, first, that "whatever resources are necessary for health care delivery, can be achieved only by careful and successful budgeting; and second, that organizational behavior must be such that it enhances the budget." These basic assumptions lead to the three rules for managerial behavior. All members of the Navy Medical Department:

a. Must be rational;
b. Must be effective managers; and
c. Must behave pragmatically.

The rule of rationality refers to the rationality of budget execution, which is always the requirement to economize means to achieve the desired ends. Effective management, as required by the budgetary imperative, is related to

management of the immediate. Captain Morin notes, "Commanding Officers, Chiefs of Services, and all Medical Department officers must manage the immediate affairs of their areas of concern and, in so doing, they must learn to obtain and to husband resources. Medical Department professionals cannot rely on the comptroller, budget experts, and other administrators to obtain and husband these resources, nor can they lay the blame on these members when budgetary execution goes awry." The final rule - pragmatism - will allow the promotion of a healthy budget while remaining healthy in a challenging environment. This rule requires expedient behavior. All members must be aware of the need to deal with problems expediently and practically.

Our senior officers agreed that an excellent hospital will realize the budgetary implications in all their endeavors and also realize that resource achievements will best be a result of expert budgeting. They will have translated their health care goals into meaningful budget language in which rationality, pragmatism, and management are clearly visible and measurable. The excellent hospital will stay within their budget. They will use their resources wisely and execute the plan of action, the budget, in congruence with the goals and mission of the Navy Medical Department. They will have the full support of all personnel within the command to "keep the costs down". Personnel will be aware of the budget with its constraints, and will have been innovative enough to accomplish the mission within those constraints. For example, a captain noted that even though an excellent command may be operating under severe budget restrictions, they get the job done through their own innovations and without requesting additional funds. The best hospitals are well aware of their budget and plan effectively within the constraints given by it.

1. Taking the Pulse of our Human Resources

I found that most of our senior officers keep a watchful eye on personnel actions that are forwarded up the chain of command. There was a general consensus that they could derive a pretty good picture of a command's leadership and management practices by listening to what the personnel of that command are saying. By monitoring personnel requests, transfer requests, early transfer requests, projected rotation date extensions, retention rates, unauthorized absences, and others, they can paint a fairly complete picture of a command. They felt that, in general, negative reports have a direct correlation to a problem with the leadership and management functions within a command. They all concurred that there would be far fewer of these negative requests and reports generated in an excellent command. Why? As a captain noted, "no matter what kind of a job a person may have, the way he is treated has a definite bearing on his job satisfaction. This of course correlates to the management practices and leadership practices within the command. If the command is practicing a participative management style and delegates responsibility and authority down the chain of command to the lowest possible levels, then you will have a greater likelihood of satisfaction for the personnel. An excellent hospital will be practicing this style of leadership and management."

A few of our senior officers felt that at the root of this problem lies the concept of authority. In many organizations, both civilian and military, the ready acceptance of traditional authority and power is being increasingly questioned. Often, authority and power are hated and feared because of their frequent misuse. Leaders who treat people as units of labor to be restricted and under tight discipline, find that the people so managed respond in

predictable ways: they tend to feel little personal identification with the command and seek an outlet for their unused energies - perhaps in leisure or in militant attitudes and subversion at work.

Leaders frequently work from principles that have the effect of creating anger, boredom, and apathy in their subordinates. This is not the case in our best hospitals. In an excellent organization, the leadership and management style encourages the personnel to do their best. Control is in the hands of the appropriate people. They have the access to information they need to know to be "on top" of their jobs. The personnel in our best hospitals want to flourish and are prepared to put effort into making this happen. The entire organization, from top to bottom, knows where it wants to go and why it wants to get there.

The question is, can you find an indication of all this from the personnel actions received in Washington, D.C.? Some of our senior officers think so. Clearly, the tons of current literature support this view. As stated in Management: Making Organizations perform [Ref. 7], "The participative management theory tends to point strongly to the achievement of job satisfaction." What is the point then? The lesson is that the leadership and management style of a command is correlated to the personnel actions that our leadership views from their offices. An excellent hospital will have few negative personnel actions and thus fewer leadership and management problems.

2. Communication

This indicator of excellence, as defined by our senior officers, has to do with the way our hospitals communicate with the higher echelons. Most of our executive leadership felt that by observing message traffic and the various correspondance received by them from our hospitals,

they can derive a subjective opinion about that command's effectiveness. The best hospitals communicate their ideas clearly and in a concise manner. Not only are they clear, but they are the typed equivalent of a smile - not a cold-fish approach. They are written simply, they tell the senior officers what you want them to know. They say exactly what you mean. Senior officers find it frustrating when they have to carefully examine each word and make assumptions regarding what you are trying to say. The excellent hospital would ensure that their correspondence and reports are timely. Nothing makes you stand out more then being consistently late, and I don't mean in a positive sense. Our executive leadership know what they want and expect it. They don't want more questions then answers in the correspondence they receive. If you have a problem, state what it is, along with the various alternatives and their costs and benefits. Be clear about the consequences. Don't candy coat a rotten apple. As one officer put it, "the good hospital keeps us informed and shows good detailed planning when they are confronted with a situation. They don't bounce the problem up to us for resolution, they act on it and keep us informed." Another senior officer said, "they have diagnosed the problem and have initiated an appropriate treatment plan. They are not treating symptoms. A good hospital will make a complete examination of the causes, and take the appropriate course of action."

What about incident reports, congressional inquiries, and patient complaints? The precepts that I have already mentioned apply. The best hospitals will have less of these, but the ones they do receive are handled in a professional manner. They do their homework. They find the cause of the problem, make a diagnosis, and take appropriate corrective action. All that's left then is to inform our executive leadership of our plan and why we chose our particular approach.

3. A Credentials Check

Our senior officers all felt that they can judge the effectiveness of our hospitals by monitoring the results of the Inspector General's inspections and the Joint Accreditation Committee's results. This was a unanimous indicator of excellence amoung the senior officers I interviewed. Some felt stronger then others. For example, one officer gave me a recommendation for an excellent hospital based almost completely on the fact of its recent accreditation results. Others however, put less of an emphasis on it. One of our senior officers stated; "Accreditation is one aspect that can give me an indication of excellence. If you don't get accredited, then your doing something wrong. However, just because you get a high accreditation rating doesn't mean your an excellent hospital." What he was saying was simple. If your truly an excellent hospital, your not going to experience the same pain with the process of accreditation. Most of our senior officers were careful not to put too much weight upon this indicator, or with any other single indicator. If you view accreditation as the indicator of excellence, you're going to miss the target.

We have all experienced, within our careers, the crisis situation prior to accreditation and the long hours preparing for it. An excellent hospital wouldn't have to prepare to such a great extent. Be aware, I'm not saying that an excellent hospital would not have some of those pre-inspection behaviors occurring, they would just occur to a lesser extent. One executive said it nicely. "An excellent hospital would have less problems preparing for, and receiving a high accreditation rating than others that we may have out there."

Don't let me give you the wrong opinion. Accreditation is an important indicator of excellence, just

like all the others that I am presenting to you. However, as our leadership has pointed out, they are only indicators. Taken together, they may paint a good picture of excellence. However, you don't hang your hat on just one or two. Accreditation as an indicator of excellence? You bet. Accreditation is the indicator of excellence? Wrong, there are just too many other variables involved to make a claim like that.

4. Efficiency as a Measure of Excellence

Most of our senior officers I talked with had a definite bias towards efficiency. In fact, as the interviews wore on, a few of them kept coming back to this indicator as the mainstay of the Navy Medical Department in determining excellence. One of our senior officers stated that of the three indicators of excellence he gave to me, meeting productivity goals and productivity reports as a means of determining efficiency was the highest priority. Exactly what do they look at and monitor to determine how efficient a hospital is? I had the same question. Some of the senior officers stated they looked at waiting time per patient, appointment time, cost per patient day, cost per procedure, and overall costs to run the facility. Another measurement that was discussed was Average Daily Patient Load (ADPL). However, they also pointed out that there were problems with trying to measure efficiency within Navy medicine. One of our executives made the following comment.

> "The size of the facility has a lot to do with how well they meet productivity goals. The reason for that is probably because there is a training contribution in the larger facilities which does not make for good productivity. It creates other problems also. We task these same facilities to provide the bulk of the Mobile Medical Augmentation Readiness Teams (M-MART) deployments. So these commands have M-MART deployments, yet we charge them as if they had none."

Another factor which leads to problems in using normal efficiency measures as a primary measure of excellence, shared with me by other senior officers, was the real difference in case mix at the various types of facilities. However, as they pointed out, the new Disease Related Groups (DRG) system that is presently being implemented will assist in overcoming some of this.

Some of our senior officers feel that a good means of measuring efficiency is through the use of productivity goals assigned to each facility. These productivity goals are based on "the population data which is generated from the RAPS system, CHAMPUS workload that is not being seen at our facilities and lastly, based on the staffing that each facility has been given." These are then taken into consideration and goals are set to see a certain number of patients in a given period. This they felt would give them a good indication of who uses their resources efficiently and therefore are excellent.

5. Patients Perceptions

This is the last, but by no means the least important external indicator that our senior officers discussed. There was once again, a difference of opinion among our leadership regarding the importance of this particular indicator of excellence. However, they all agreed that it was an indicator that they look to in determining how well a hospital is functioning. Some of our executive leadership felt that the patient's perceptions do not really tell you much about the quality of care. It's just a perception. Others felt strongly that those perceptions tell us a lot. As one of the interviewees stated, "After all, what are we in business for? Aren't we here to satisfy the needs and wants of our customers, regardless of whether they be congress, commanding officers, or beneficiaries of the

system." He agreed that the quality of care has to be the best that we can possibly offer, both in combat medicine, and in the beneficiary arena of our medical system. In the same context though, the actual quality of care can be superb, but if our customers don't perceive it to be, then we have a very real problem. Another senior officer commented, "If we were a civilian service organization, and we failed to address the need's of our customers, we would be closed down in a very short period of time."

This whole arena of patient perceptions is a very real concern of our senior officers. But they are also aware that in our health care system, it is difficult to meet all the wants of our customers. Two of our senior officers put it this way. "Even though we assign a mission to each hospital to meet the needs of the beneficiaries, as well as contingency for war, we in the past, we being the Navy, have not necessarily assigned the assets, both in numerical and in mix, to meet the population needs of that particular institution." Our leadership is well aware of the problems of the heavy load we in our hospitals face. They are also aware of the real need to satisfy the desires of the patients. As I have already pointed out in a previous section, our senior officers feel that we in the medical profession can come a long way just by remembering our "bedside manner". A smile and an explanation go a long way in meeting the needs of our beneficiaries. Due to this, our senior officers do place a significant amount of importance to the aspect of patient perceptions. An excellent hospital will have less complaints and congressional inquiries. Their patients will feel that they are important. The patient satisfaction survey will show positive results.

The general consensus of our senior officers was that our best hospitals will have a strong shared belief and value that they are there to serve the patient. In an

article from Evaluation and the Health Profession [Ref. 8], Getzen defined that which are leadership has described. "The operational definition of quality is that which attracts patients." This aspect of excellence is what were about. It's what the majority of our leadership felt would make the difference between an average hospital and an excellent hospital.

## C. INTERNAL FUNCTIONS OF AN EXCELLENT COMMAND

These are the indicators that our executive leadership feel would be present within an excellent hospital. They are those internal functions that keep the organization operating much in the same sense as our internal body functions keep the human body alive, healthy, and functioning. They are just as important to an excellent command as our internal organs are to our healthy body. If one does not appear to be functioning properly, then the organization does not perform to its potential. I draw this analogy because I believe that it is difficult to prioritize any of these indicators. As you read them, you will find, as I did listening to our senior officers, that they all interrelate. Together, they lead to excellence. With this in mind, I give you the "Internal" indicators of excellence that our leadership has expressed.

### 1. Golden Nugget Syndrome

The title of this indicator was given to me by one of our senior officers during my interviews. To him, those three words described an aspect of excellence within a hospital. He felt that in most of our commands, we often find a hesitancy to fully use the talents of our personnel resources. He said, "In most hospitals, we have a resource sitting there waiting to be used. All we have to do is tap

it. That is what I call the "Golden Nugget Syndrome". Underneath that veneer of sand that most organizations develop, we will find, if we just scrape it away, that there are a lot of golden nuggets just waiting to come up and assist the organization." The best hospitals have scraped away that layer of sand. They use those precious resources. They give them responsibility and demand involvement and growth from their personnel. They delegate specific authority and responsibility and hold them accountable. This occurs throughout the chain of command. A captain stated, "This is nothing new. It's what has made the Navy so great throughout our 200 years." It's sound management practices. Effective delegation is one of the truly significant attributes of successful leaders and organizations. It is only by getting work done through and by others, that organizations can perform and prosper. It's the scraping away of the sand to find and use those golden nuggets that the senior officers spoke of. It's making all within the organization winners. Peters and Waterman alluded to this same principle. They said that in a recent psychological study when a sample of adults were asked to rank themselves on the ability to get along with others, everyone of them rated themselves in the top ten percent of the population. They were careful to point out that we all think were tops. Yet in most organizations, including hospitals, we find the organization takes a negative view towards people. They verbally accost members for poor performance, they call for risk taking but then punish failures. The lessons that our excellent hospitals provide, say our senior officers, is that they reinforce the positives. The people have a winning attitude that permeates the command. They strive for additional responsibilities and growth. This, in turn, provides that excellent command a greater brain thrust to move into the future, to be innovative and challenged.

This is a function of the leadership within the command say our senior officers. It starts with the commanding officer who delegates to the executive officer. He in turn delegates to the "Board of Directors", that is our Directorates. It means being clear and concise. It means getting through the sand and exposing those golden nuggets. This is truly an indicator of excellence that our senior officers see within our best hospitals.

2. A Concern for Personnel Development

Our executive leadership felt strongly about the area of personnel training and development. So much so, that they seemed to put a great deal of emphasis upon this indicator. This indicator entails much more then a formal education and training program. Don't take me wrong, an effective training and education program is important, but there is much more that goes into making an effective sailor or officer than just training. Such things as pushing responsibility down the chain of command; Putting junior personnel in leadership positions as early as possible so as to develop their skills; Ensuring that Third Class Petty Officers are given responsibility and leadership opportunities commensurate with a junior Petty Officer; Ensuring that junior personnel develop and generate the first chop on their subordinate personnel's performance evaluations. Of course this is in addition to a viable technical training program for professional development. As one of our senior officers said, "Our corpsman and junior officers deserve and expect a well rounded development program. Not only do they deserve it, but out Navy Medical Department of the future demands it." Another senior officer commented that " our best hospitals have a well developed and balanced training program. They know the importance of quality technical training and the absolute requirement for leadership and management training."

Our best hospitals focus on the totality of personnel development. In my opinion, one of our executives said it all: "After all, doesn't the future of the Navy and the Navy Medical Department lie within our personnel?" Another officer stated, "it is tempting to cut back on training and to do tasks yourself, especially when time is short. However, the short-term gains in time fail to balance the long-term costs in low morale, poor performance, and slow career development." Our leadership felt that this indicator was of great importance for obvious reasons. Personnel development is indeed an indicator of excellence in the eyes of our leadership.

3. United They Stand, Divided They Fall

Teamwork was considered to be a major factor in our best hospitals. Without it, our senior officers felt that the probability of achieving excellence would be severely hampered. As one of our executives commented, "a successful command is one that has the gift of being able to get people involved. They have cooperation." That's an important observation since cooperation can't be enforced, it can only be won. Cooperation, as a senior officer pointed out, "implies teamwork - people working together as a group." Thus, it's more then performing assigned duties for which you may be responsible. Our leadership felt that teamwork began at the top of the organization.

In our best hospitals, they observed that the Commanding Officer, Executive Officer, and the Directorates would work together much in the same way a board of directors would function. They would be functioning together in harmony towards a specific end result. You wouldn't see, as we often do say our executives, the Director of Nursing doing battle with the Director of Administration. You wouldn't see the Director of Surgery doing battle with the Director of Medicine. Together, they know their strengths

and weaknesses and plan accordingly. As one interviewee pointed out, "In an excellent hospital, the directorates know each other well enough that they can anticipate anothers thoughts on a subject even before they think them." That's teamwork. Our leadership kept repeating such stories. However, they were also certain that this close teamwork would not be present in our average facilities. They made it clear that the teamwork would permeate the command. From the Commanding Officer to the Executive Officer, from the Executive Officer to the Directorates and on down through the chain of command. The common factor would be that were all in this together, pulling together to make that end result happen.

Our best hospitals indeed ascribe to the adage "United we stand, divided we fall". However, this is nothing new. The literature has pointed this out for years now. But if that's the case, why aren't all our facilities functioning in this manner? As with many of these indicators that our senior officers have shared with us, the answer may lie with the leadership skills of each facility. Social scientists describe an effective team as "individuals welded together into harmonious groups whose output is high; work habits, good; and absenteeism, low. In general, members of these groups are bound together by empathy and organization, interested enough in group activities to overcome conflicts and to develop a zeal for shared tasks, and aware that individual needs must be met in order to attain common goals" [Ref. 9]. Clearly, the responsibility for helping to bring these factors into focus is largely the leader's. To maintain and develop a cohesive team, all members must work together and very importantly, keep the other person's point of view in mind.

Yes, teamwork is important. In fact, listening to our leadership, it's a powerful key to the development of excellence in Navy health care.

4. Management by Making Rounds

Some of our senior officers felt that our best Commanding Officers would find the time in their busy schedule to make rounds on the patients every day. This, they felt, was an invaluable source of information for the Commanding Officer and the command. It provides him with immediate feedback on the health care provided within his facility directly from the patients using his services. It allows the captain to keep his finger on the pulse of the organization.

In addition to patient rounds, a few of our executives felt that the commanding officer, if a medical corps officer, should keep his hands in the direct patient care arena. By doing such, he has the same contact with all the problems the other physicians within his command face on a day-to-day basis. One senior officer said that this allows the Commanding Officer the unique opportunity to see how laboratory results are returned to physicians. Are they legible? Do they make sense? He can also keep track of scheduling problems that the other physicians may be encountering. For example, one of the interviewees related a story to me about when he was a Commanding Officer and called the main operating room to schedule surgery for the next morning. He was told that the supervisor was not in that afternoon. He asked that the next senior person make the scheduled appointment. The young corpsman responded that the supervisor was the only one who could make the appointments. Of course this was taken care of immediately, but it does point up an example of what our leadership was talking about. It keeps the Commanding Officer involved within his organization, not just on top of the organization blinded from its day-to-day operations. Some of our senior officers felt that these practices would be ongoing within our best

hospitals. It's another method by which to keep their fingers on the pulse of the command and to evaluate the performance of the command. These practices allow the captain an opportunity to identify potential problem areas and resolve them before they erupt.

However, this was once again another aspect from which our leadership did not share a common belief. Some of our senior officers felt that, unless handled very carefully by the Commanding Officer, his involvement in the daily operation of the hospital could create crises within the command. He may be overriding his subordinates authority. This difference of opinion could be a direct result of the profession and corps of the senior officer. There seemed to be a direct relationship between the view taken by each leader, and their respective corps. For example, the Medical Corps officers felt that the Commanding Officer should continue to treat patients. The Nurse Corps and Medical Service Corps officers felt just the opposite. However, the majority of our senior officers did feel that our best hospitals' Commanding Officers would be out and about, seeing the patients, visiting them on the wards, and keeping a watchful eye on the command's operations.

5. Medicine and our Public

"We don't like to talk about the fact that we are in a marketing environment and that public relations is important, but we are, and it is." This was a quote from one of our senior officers I interviewed. He went on to say: "We are in a unique marketing and public relations environment. We have to sell all of our products to two distinct categories of people." He was talking about our direct beneficiaries of our health care system and of course the Department of Defense and Congress. "Our excellent hospitals will understand the importance of marketing and public relations

within the community they serve." They will strive to fully understand the needs of the personnel within the community. "After all," said one interviewee, "regardless of either mission, the beneficiary care or contingency for war, our purpose is to satisfy the needs, wants and desires of our clientele." As stated by many of our senior officers I interviewed, that means that we "keep in touch" with our customer's needs. We must provide the best technical quality care that can be offered, both in combat and in our shore based facilities, but we must do so in conjunction with the understanding of customer's desires. Our best hospitals are concerned with public relations and have active programs in effect to address this need. One executive described what he felt to be an excellent command and related the following account of how aggressively they work towards the public relations aspect.

> "This hospital that I just described to you actively pursues positive public relations. They have a very active health care consumer council. They respond to negative trends that may begin to show in the patient satisfaction surveys. They developed a group of advocates within the community they serve who actively support the command and even donate funds to the hospital. Of course these funds have to go through all the regular approval channels before they can make use of them. But the point is they have someone out there in the community who really cares about the command and what's occurring in it. They are in touch with the community they serve and the community is highly supportive of them."

Our best hospitals are aware of the need to build networks with the variety of communities they serve. They spend time being visible to the communities. They take time to understand the needs of the communities they serve. This can't help but have an effect upon excellence. I can see why our leadership also feels so strongly about this indicator.

6. Pushing it Down the Organization

Delegation down the chain of command is considered to be an important aspect within our best hospitals. Our senior officers discussed it repeatedly during my interviews with them. Delegation was also discussed in many of the other indicators I've shared with you thus far, but it seemed to me that our senior officers felt so strongly about it that it really deserves a place in the spot light of its own. Why was it discussed to such great lengths? The answer lies within many of the other indicators within this chapter. It's part of using our personnel effectively. It's part of the development and training of our personnel. It's part of developing the brain trust of the organization to move smartly toward the future. One of our senior officers summed it up nicely for me. "I believe fully in delegation. Responsibilities, accountability and the authority ought to be pushed down to the lowest levels. If an organization does that, what you will see is a well run hospital." Most of our executives felt that delegation is the key to personnel development. But they were also quick to point out that it starts with the commanding officer. If the commanding officer is hesitant in delegating, then the process doesn't work. As one of the interviewees stated; "What you will most likely see in our average facilities is that the command is not mature enough to understand the concepts of delegation. They want control, they want everything up front. When you have that kind of a command, you get chaos, you've got disgruntled employees, you've got lackidasical work being done at lower levels." The commanding officer, say our senior officers, must set the example. He must go out of his way to let the executive officer make most of the decisions and strive to inturn, ensure that the executive officer does the same. It continues all through the organization. One of our executives put it this way.

"If this happens, your going to have an excellent, sweet command. I love to see a command like that. I would love to see a commanding officer with nothing more to do then to sign four pieces of paper a day. So long as he has his finger on the pulse of the organization, and if he is a delegater, he should get this from his division directors."

However, one of our senior officers felt that we sometimes violate the true principle of delegation. Responsibility must be matched by authority and accountability.

"If you hold your department head responsible for the efficiency of his department, then in an excellent command, he will be given the freedom to assign and work his personnel as he sees fit. He is given enough freedom to reward and punish his own men. If he is only allowed to supervise the work of his men, without the power to reward them or to show his dissatisfaction, then his authority is being unnecessarily hampered."

Our best hospitals understand this and work to ensure the success of this key indicator. Its principles permeate the command from the commanding officer to the junior petty officer. Without this indicator, the chances of excellence is indeed poor.

7. <u>They Know Where They're Heading</u>

There was no doubt that our leadership felt that an excellent hospital will know where they want to go and will have planned exactly how to get there. As one of our senior officers stated,

"Our best hospitals and their executives, have a firm hand on the future for their organization. They have specific goals which are understood and supported by all within the command."

Our senior officers felt that these goals and plans for the future would be accepted and known even to junior personnel within the command. After all, as one executive stated, "if you don't know where your boss is going, how are you going

to help him get there?" As our senior officers pointed out, this is nothing new. This indicator is just one of the basic principles of sound management. However, some of our executives also pointed out that we sometimes fail to ensure that our subordinates are aware of our goals. This however is not the case in our best hospitals.

> "What you will find in an excellent hospital that you may visit, is a complete understanding by all personnel on what the commanding officer's policies are and where he is trying to go. You should be able to talk to anyone within the command and receive the same comments. They might say it a little differently, but they will all know where the commanding officer is headed."

They were careful to point out that the directorates and other key departments will also be aware of what their responsibilities are to help achieve the desired ends. Does this sound a lot like good communications? That's definitely a part of it. But the key still remains the setting of goals and ensuring everyone within the chain of command is aware of them. They will know their responsibilities are to aid in their fulfillment. If this principle is practiced, and everyone within the command is pulling towards its attainment, "then your going to have a sweet command, capable of handling any mission that we may assign." That's one of our senior officer's beliefs. Yes, they felt that "Knowing Where Your Going" is definitely an indicator of excellence.

8. A Steadfast Concern for Quality

"Quality health care is our prime concern. Without it, were not doing justice to those we seek to serve." As this interviewee stated, quality care is an important aspect of excellence. For without this particular aspect, you cannot have excellence. What our leadership was talking about was providing the best technical medical care that can

possibly be provided. There was no difference of opinion regarding this particular indicator. They all discussed it. As one senior officer commented, "quality health care is what it's about. Whether it be in our fixed facilities, or in support of the fleet and Marine Corps, it has to be our highest priority." Our best hospitals are aware of this and strive towards the highest quality medical care that can be given.

> "They have an active and viable Quality Assurance program in place. You won't find our best hospitals giving lip service to the program. They have dedicated, talented personnel in charge of the program who make it their responsibility to stay at the forefront of the quality assurance field."

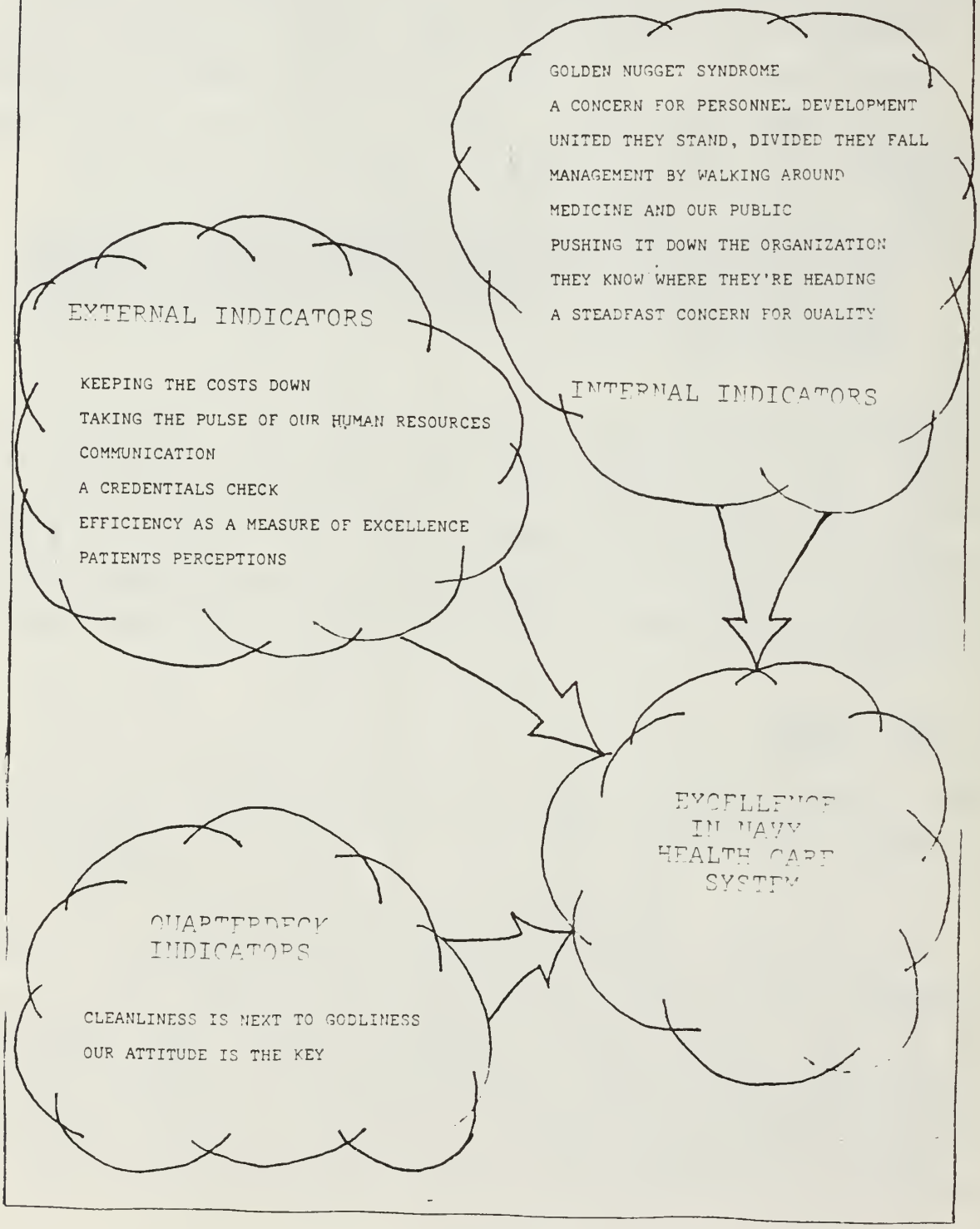
Another senior officer stated that you would find that our best hospital's personnel are concerned with the quality of care that they provide. From the commanding officer all the way down the chain of command to the ward corpsman. Quality assurance will be a daily activity in everyones minds. Without the technical quality of medicine, excellence cannot be achieved.

D. SUMMARY

Well, there you have it. These were the views of our senior officers on the topic of excellence within Navy health care. Table I depicts the model of excellence that our leadership envisioned. All three of these viewpoints taken together, target that ever elusive "excellence in Navy health care." Can I prioritize each? I don't believe so. It's as if an excellent hospital needs each indicator working together just as our human body needs our vital organs working in harmony. Take away one or two and you begin to have problems.

TABLE I

Executive Leadership's Model of Excellence



Was this vision shared by all of our executives? No, not really. During the interviews with the fourteen senior officers, I found a slight difference of opinion regarding some aspects of excellence, and with others, there were strong disagreements. Upon further examination though, I discovered that a majority of these differences were between corps and professions. It was clear that the educational background, the values developed, leadership beliefs, and management practices differed between our corps. This was not the case in another study that has recently been conducted in the surface warfare community [Ref. 10], by Cdr. Gregg Gullickson and Lcdr. Richard Chennette. In their study, they found that surface warfare senior officers all concurred on what excellence in the surface Navy would like like. They all spoke of the same indicators. This posses a unique problem for us within Navy medicine. Can you imagine four distinct professions on board a ship trying to cooperate to meet its mission and at the same time keep it on course. That's exactly what we have to do. But there was a bright side to all of this. When I took aspects from each corps that were mutually agreed upon, they definitely painted a truly inspiring picture. Is there really any hospital or health care facility out there that meets these standards of excellence? That was the final question that I asked our senior officers. Between them, they gave me over nine commands to observe. But when the votes were tallied up, only two commands had received the majority of the fourteen senior officers ballets. The third hospital had received noteworthy mention by six of the fourteen executives. The remaining hospitals had been mentioned less then three times and because of that, were not observed in this study.

The discussions regarding what I found in these three hospitals is my next chapter. Lets go on a trip to each of

these facilities that our leadership gave me. Sit back and relax as I describe what I found.

## IV. PICTURE OF THE BEST

This was the most enjoyable part of this research project. I'll have to admit, I was a little skeptical as I set out to visit the three hospitals identified by our executive leadership. However, I found that I was pleasantly surprised. They are out there. You could actually feel the difference as you entered the command. My approach in gathering information from these commands was much the same as the approach I used in determining the executive leadership's vision of excellence. My open-ended, semi-structured questions were once again developed using the McKinsey 7 S Model as a base line. I made it a point to visit each command at 0800 at which time I conducted one hour interviews with the following personnel:

a. Commanding Officer
b. Executive Officer
c. Two or three directors
d. Three department heads
e. Command Master Chief
f. Two Chief Petty Officers
g. One first class petty officer
h. Five E-5 and below personnel

In addition to the interviews, I was able to sit in on a few of the command's morning report meetings and view other documentation including survey and inspection results. I won't bore you with anymore of my methodology for approaching these commands. Let me just share with you those indicators that seemed to be present and which seem to have driven them to the forefront of Navy medicine. These indicators were difficult to boil down and I found myself floundering on more then one occasion. However, I was finally able to develop these following indicators:

- The Captain is Out and About
- The Best Darn Little Hospital in the U.S.N.
- Teamwork
- Attention to Patient Satisfaction
- Not Only Are They Good, They Look Good
- Development of the Future
- A Bias Towards Action
- Staying Close to the Patient
- A Key To Success: The Captain
- Efficiency is Important
- Delegation: A Way of Life
- The Chief Petty Officer

It must be noted that none of the commands I visited displayed all of these indicators. However, I did notice that most of them were present at two of the three hospitals that I visited. The interesting point was that none of them seemed to have all the attributes I shared above with you. Some of these aspects of excellence were common to each. But like I said, not all. But enough of this. I'm sure that you, just as I was, are anxious to see what these commands are doing that make them the best that we have to offer.

## A. THE CAPTAIN IS OUT AND ABOUT

The Commanding Officer's of our best hospitals make it a point to make rounds of his command at least twice a day. Not only does he make rounds on his patients, but his staff also. You might have the same question that I did. Where do they find the time? The answer was straight forward: they make the time. One of our Commanding Officers put it this way. "It's vital to a solid command that my personnel can put a face to my name. It's also important that I know each and every member of my command by not only their face, but by their first name." The Commanding Officer in one of our

best hospitals carried this one step further. Not only does he make it a point to get around and talk to all of his personnel on a daily basis, he knows each of their birthdays and other important dates. On such days, the individual receives a birthday card from his commander and the day off, if at all possible. Be aware, this is no easy task. These Commanding Officers spend an average of 12 - 16 hour work-days to pursue such a rapport with their personnel. Why so much? As one captain pointed out, he needs to get into work early enough so that he can visit his "night shift" personnel. He also needs to stay late enough so that he can talk to his "PM" crew.

What does such a practice by a Commanding Officer offer a command? How about commitment and loyalty. In one hospital alone, I interviewed twenty-one personnel from the directorate level all the way down the chain of command to the most junior personnel. They were randomly selected by myself, and yet I found not one individual who did not think the world of the Commanding Officer, or would not work 18 hour days seven days a week for him. As one captain put it, "I have no idea of the hours that my staff has worked lately. But I know, for example, that we have been putting in some long ones. Take for instance my Quality Assurance division who is cranking in about eighteen hours a day over there. It's tremendous... which is exactly like I'd expect it. They like challenges... they aren't afraid of hard work." For me, it was truly astounding. Not only does this provide rapport, but it also allows the Commanding Officer to keep the pulse of his personnel and command. One captain stated, "The only way that any Commanding Officer, make that any leader, can know how hard he can push his personnel is to get out there and monitor their reactions." Another said, "It's important that they (his personnel) know that I won't ask anything of them that I am not willing to give myself."

In fact, the captain's personnel knew this. Over half of his personnel responded to me with; "He doesn't expect anymore from us then he does of himself." As I said, the payoff for these Commanding Officers is the commitment and loyalty that seems to be generated to work those eighteen hour days to get the job done if necessary. They know their personnel and their strengths and weaknesses. They know how hard they can push them and when to let off. It's a morale booster that lets everyone know that the Commanding Officer cares.

Once again though, this is nothing new. It just seems to be a forgotten practice. Most of our leadership manuals and books discuss this indicator in length. New research conducted has further supported the need for getting around your command and knowing your personnel.

I remember reading an old copy of Navy Regulations dated 1948 which stated "An officer shall keep himself informed of the capabilities and needs of each of his subordinates." A copy of a 1952 Division Officer's Guide [Ref. 11], again cited the importance of knowing your men. "It's important for officers to know their men. A word of praise when earned, the liberal use of men's names, a friendly and confident bearing - these are all marks of good leaders. Special events such as birthdays, marriages, the birth of children... should be the occasion for congratulations." Peters and Waterman found that excellent companies also share this attribute of getting out and about and knowing your employees. They shared many of the same stories that I have described in this indicator. "Big Jim (The Chief Executive Officer of a large company) spends much of his time riding around the factory in a golf cart, waving and joking with his workers, listening to them, and calling them all by their first names - all 2000 of them." They gave another example of a successful Chief Executive Officer (CEO) who said; "The key is to get out into the store and listen to what the people have to say."

Whether you agree or not with the past and present literature on this subject, one thing is for sure. Two of the three Commanding Officers who practiced this philosophy had the complete trust, loyalty, and dedication of their personnel. They knew the Commanding Officer's expectations and strived to meet them.

## B. THE BEST DARN LITTLE HOSPITAL IN THE UNITED STATES NAVY

Without any doubt, our best hospitals knew that they were the best. From the commanding officer to the ward corpsmen, none were surprised that I was visiting their facility. Pride ran deep within the commands. In two of the three hospitals I visited, I could sense it from the minute I arrived. In all the hospitals that I visited, I would make it a point to arrive early and get myself a cup of coffee at the snack bar. There wasn't one staff member that I observed, while sitting there sipping my coffee, that wasn't in a sharp uniform and well groomed. This impression was further cemented as I made my way around the command. All the personnel I talked to knew that they were the best. They knew they provided good quality health care and felt that there wasn't anything they couldn't achieve as a unified command. In fact, one of our hospitals readily advertised their feelings. The staff developed T-shirts that read, "The Best Darn Little Hospital in the United States Navy." Almost all of the enlisted personnel and officers of the command own and wear it at numerous activities. What was even more surprising for me however, was the fact that most of the personnel in these commands were fully aware of what happened to make them feel they were the best. They had no difficulty in explaining why they had such pride in their command.

The commanding officers and executive leadership within our best hospitals recognize the accomplishments that the members of the command make. They were quick to give recognition for a job well done and to publically voice the accomplishments of the command. The command's leadership made it known to the personnel that they were the ones responsible for its' success. "For without my personnel," said one commanding officer, "all I have left is some buildings and equipment." He went on to say, "The personnel within my command are dedicated and talented, it is those people that make this command a success." A chief peety officer told me; "Everyone, from the commanding officer to our chief petty officer community, is quick to give praise and a pat on the back." On the other hand, they were also quick to point out that they address unsatisfactory performance just as fast. One of the Commanding Officers I spoke with made this comment. "I always tell them (his personnel), that if your pleased that you've done your best today, then I,m pleased, and they're going to know it. However, if your not pleased (his personnel), I'm also going to know it and I'm going to come right down your throat." All the hospitals I visited had formal award ceremonies on a once per month basis. The only difference I saw between them in this aspect was the ceremony itself. Two of the commands had their ceremonies in the Commanding Officer's conference room or auditorium most of the time. The third hospital however, performed the ceremonies outside whenever they could, and in a military formation. It shouldn't surprise you that the personnel I spoke with actually enjoyed the ceremony in this fashion.

In addition, these hospitals didn't feel it was bad to hand out a great deal of awards. Some officers I've talked to in the past see overwillingness to hand out awards as a weakness, that this waters down the meaning of the awards.

Peters and Waterman however, claim that outstanding companies try to reward as many people as possible in their companies. Our best hospitals agree. They uniformily believe that the ready use of rewards, even for small achievements, encourages good performance. A key really seems to lie with recognition. That's what seemed to drive the pride. Not just doing well in inspections and the accreditation process; they all felt that they were important too, but being recognized for your contribution to the results of those inspections, good or bad, was the most significant factor.

One of the Commanding Officers of our best hospitals told the story of the way he related the results of a recent Joint Commision on the Accreditation of Hospitals (JCAH) inspection to his staff as an example of the importance he attatched to the recognition of the accomplishments of his personnel. Just prior to a scheduled personnel inspection, he received the package with the findings of the JCAH inspection. He chose not to open it, but to carry it with him to the inspection. He carried it with him as he went from person to person inspecting them. When he had completed, he returned to the front of his personnel and stated that he had just received the mail prior to coming out for the personnel inspection. He told his personnel that he thought that he had in his hands the results of the JCAH inspection. He shared with them his feelings that the results weren't his, but theirs since they were the ones that made it happen. With that, he opened the package and read the findings. As he read, it became apparent that there were no discrepencies. He then told me "You would have thought that we were at the Naval Acadamy graduation." Hats flew, personnel jumped up and down. They were estatic with their achievement. This type of recognition was apparent at our best hospitals. I didn't get the impression that this was planned by our hospitals, it wasn't a concentrated

effort. "It's just part of sound leadership practices", said one middle grade officer.

C. TEAMWORK

From the very top of the organization to the very bottom, there was a sense of teamwork with everyone I interviewed. Regardless of the profession or corps designator, there was the prevailing attitude that were all in this together. "We're all working toward the same desired ends." There was no obvious in-fighting between the directorates and departments. They all worked well together and knew their respective strengths and weaknesses. That's what makes the difference", said one Commanding Officer. His "board of directors" worked together as a cohesive team. "I give them the problems because they work well together. I let them as a team, come up with alternatives and solutions. If they weren't a cohesive group working together, I couldn't do this. They're doing well together. I think that they operate the same way with their respective departments."

What the captain was saying is that his executive leadership within the hospital have endevored to develop cohesive groups that will transform their respective cohesiveness into greater productivity. They are working together to achieve the desired outcomes of the command. THey are not working individually to gain results for their respective departments or empires. The Commanding Officers of our best hospitals recognize the importance of team spirit. One directorate I talked with put it in these terms. "Many officers find teamwork and cooperation between their contempories difficult. After all, we are, in a sense, competing for promotions; it's difficult to help anyone who seems to be a competitor. Yet, in the long run, helping each other is to our best interest. It speeds the jobs to

completion and almost always gives us a better product then if we would of worked on it alone." It also includes another aspect that this directorate failed to comment on. It shows the superiors that they have the perspective to consider the needs of the command ahead of personal needs and desires.

It was also interesting to note that each team within the command hierachy was relatively small. This is, of course, by Navy organization and design, but none the less important. The directorates are made up of four to six personnel, the department heads consists of eight to ten personnel, etc.... Peters and Waterman found that teamwork and small teams seem to be a key to excellence [Ref. 12].

> "It's also quite remarkable how effective team use in the excellent companies meets, to a tee, the best academic findings about the makeup of effective small groups. For instance, the effective productivity teams in the excellent companies usually range from five to ten in size. The academic evidence is clear on this: optimal group size, in most studies, is about seven."

So the question is how is this teamwork within our best hospitals achieved? The answer seems to lie with the Commanding Officer's ability to get his officers and personnel involved in planning, decision making, problem solving, and implementation strategies. They have developed a sense of committment with their personnel to make the command the best. There seemed to be a sincere effort, made by our best hospitals, to centrally locate the directorates in one area, close to each other. One directorate stated, "involvement leads to committment to the group and to the command. Being together like this helps to facilitate that involvement." However, without any doubt, all the personnel I talked with felt that the climate for this cohesiveness all started with the Commanding Officer and the Executive Officer. They set the tone for the teamwork and the team development to take place.

D. ATTENTION TO PATIENT SATISFACTION

The Commanding Officer's of our best hospitals had a true concern for patient satisfaction. They personally read and responded to letters of complaint as well as "Bravo Zulus". They made it a point to get out and about and talk to the patients in the hospital, both inpatients as well as outpatients. One of the Commanding Officers commented, "I make rounds everyday and I see every patient in the hospital. I can find out from each patient exactly what's going on... and ask specific questions about the clinical care provided. I really track that. It's important to me. I know all the patients. I don't know them well, but I know of them and who they are." Our best hospitals stress two dimensions of quality patient care: The technical quality of care monitored through peer review, and the patient's perception of the care they receive. They have an active and agressive quality assurance program with key personnel assigned. In fact, in one of the hospitals that I visited, the quality assurance staff was comprised of a medical corps officer and a nurse corps officer. That kind of manpower placed into the program gives you an indication about the emphasis that this Commanding Officer placed upon the quality assurance program in our best hospitals. Our best hospitals were fully aware that even though they might be providing excellent technical medical care, if the patients do not perceive it the same way, then they have a <u>real</u> problem to deal with.

It was interesting to note however, that only one hospital out of the three that I visited, had been able to push this particular value down throughout the chain of command. In this particular hospital, everyone I talked to, with the exception of a few medical corps officers, had the prevailing attitude that the patient comes first. They all

felt that the patient was the reason for our existance. One nurse corps officer stated, "The patient is the only reason that you and I are wearing this uniform." I observed behaviors in this one particular hospital that I've not seen in other facilities. I saw staff members stop to help a patient in the hallway who appeared to be lost. I saw staff members get up from behind their desks and actually walk lost patients to the appropriate clinic. I saw a staff member go out of his way to take a patient's son down to the snack bar to help him get a drink. This was the behavior exhibited by most of the personnel. Their attitude towards patient care and the patient's needs were embodied in their actions as well as their words.

The junior enlsited personnel understood the importance of patient satisfaction and the command's philosophy towards it. They all made these type of comments: "If there is one thing that the Commanding Officer values, more then anything else, its that the patient comes first." They knew this, believed this, and thus operated accordingly. But the question still persists, how did these commanding officers achieve this? How did they set this value system in place? The answer lies within my next section. Read on, it becomes even more interesting.

## E. A FOCUS ON WHAT'S IMPORTANT

Without exception, the commanding officers that I talked to came into the command with a clear direction and philosophy for the organization. They made certain that the personnel under their command knew what was important for the command to achieve the desired end results. Two of the three commanding officers made it a point to see every newly reporting person within the command, to share with them his ideas of what was important to him. One of the commanding officers shared his method for accomplishing this:

"I see all personnel who check-in at least twice. Once the day they check-in, and once at indoctrination training. I take the opportunity on both occasions to tell them my philosophy regarding command. I tell them that the patient comes first. I tell them that they have to look good at all times. I tell them that they are professionals and must act as such 24 hours a day. This is their chance to make the command the best ever. I tell them that their behavior and actions should always be helpful and positive towards the patients."

It was clear to me that all the Commanding Officers of our best hospitals, just as this one, put an emphasis on the patients. In addition, they were cognizant of our primary mission, contigency for war, and readily shared this with the personnel within their command. They were also aware of the fact that words are nice, but actions speak louder and have a greater impact. In two of the three hospitals that I visited, they established policies and instructional programs that supported their beliefs. Both commands had active indoctrination programs. Both commands held training in combat medicine and patient care. Behavior towards the patient as well as technical training was emphasized in the training program. The Commanding Officers made it a point to be out and about, talking to the patients and staff, reinforcing his poicies regarding the behavior he desired his personnel to exhibit towards the patients we serve. Setting a value system and a culture within the command was a high priority with our best hospital's Commanding Officers. They insisted on behaviors consistent with the command values. They dealt with personnel who did not exhibit appropriate behaviors in a professional manner. Personalities were not attacked; only actions were criticized. The Commanding Officers expected their executive leadership within the command to set an example. They relied upon the chief petty officers within the command to ensure that the command's values were emphasized at the enlisted levels. All in all, the Commanding Officers of our best hospitals, spent

considerable time and effort building and maintaining a value system of "patients first". One captain's response to my question of what he and his personnel value in their command was; "What is the value that perdominates this command? That we take good care of our patients. We have a reputation for doing that out in the community we serve. My staff doesn't want to do anything to impinge upon that. That's it. That's what were in business for. As far as I'm concerned, patients first, staff and anything else second."

F. NOT ONLY ARE THEY GOOD, THEY LOOK GOOD

Our executive leadership hit this one on the head. Our best hospitals were immaculate. In two of the three cases, as I drove up to the hospital, I was impressed with the facility and the grounds surrounding it. The grass was mowed and trimmed. The bushes were trimmed neatly. There was no trash laying about the area. I was even more impressed as I went into the commands and walked through their passageways, clinics, and departments. The floors and carpets were impressive. The brass and metal trimmings throughout the command gleamed and glistened. The bathrooms were clean, polished, had plenty of toilet paper, and didn't even have graffetti on the walls. The personnel were also impressive. All had good haircuts and their uniforms were clean, neat, and worn with pride. There was a sense that this was indeed a military hospital, and the personnel were proud of it. This doesn't mean that the third hospital wasn't clean or the personnel didn't present a a neat appearance. They just weren't as impressive. I didn't get the same impression when I arrived. The grounds in the third hospital were not groomed as nicely. The passageways were not <u>as</u> clean. Some of the personnel needed haircuts, and failed, on numerous occasions, to render appropriate military honors to

officers. However, as I have already mentioned, this wasn't the case in the other two commands that I visited.

All this was driven by one particular aspect above all else: Pride in the command. It wasn't a dictated "you do it or else" approach, but an internal pride inherent in all the command personnel that seemed to maintain the plant and its' sailors at such high standards. As one of the Commanding Officers stated:

> "It's the pride that my staff have in the facility. My hospital is clean, beautifully clean. It's kept clean... my stairways are cleaner than a lot of peoples floors... because my personnel care for the command, and they're proud of it. Its the atmosphere. Its the mood that we've established that keep it this way."

He went on to give an example of how his command impacts upon his personnel and the patients they serve.

> "This morning for example, driving to work in the fog... the fog was all around except for at the hospital. The sunlight was shining on the hospital as you came around the corner, it stood out. Sort of like the morman temple, it really is beautiful. My people and the patients feel that when they come in. They are proud, eager, and enthusiastic when they get here. I believe that the whole aura of the place lends itself towards being an excellent institution."

Another Commanding Officer related a story of how his staff, civilian as well as military, takes great pride in the hospital and its appearance:

> "If my civilian staff starts to see somebody throw a cigerette on the floor, they go over to the individual and ask them not to throw the butt on my floor. So they hold an identity with the hospital. The food service staff is similar... they have a lot of pride in their job. You can see it. They bubble that pride over to the rest of the staff. They do it despite the fact that these two areas are coming up for contracting... which is very interesting, because they know it's coming but they still have that same sort of pride in the job."

What is the key for developing this type of behavior from our subordinates? The Commanding Officers of our best hospitals all agreed that it was making the staff feel a part of the command. Making them feel that this is their hospital. Upon talking to the personnel, I found that this was exactly the case. They did feel that these hospitals, our best, were their hospitals. They felt that they had a voice in what the hospital was doing. They felt that their job and daily functions were important and that they were contributing to the desired ends of the command. But they were quick to point out that they felt this way because the Commanding Officer and, quite often, the Executive Officer made them feel that they were important. This mood, this aura created by the Commanding Officer and his executive leadership, is what drove the cleanliness and military bearing within our best commands. They made it happen. It wasn't an accident, it was good sound leadership from the top of the organization. The commands that I visited took the opportunity, as often as possible, to show off the command. Simple ceremonies such as morning and evening colors, were conducted in full ceremonial dress including white helmet, gloves, watch belts, and anklets. The personnel I spoke with were proud of this. It was a real honor to do the colors. This is the type of pride they were talking about, and for me, it was gratifying to observe.

## G. DEVELOPMENT OF THE FUTURE

"The future belongs to my subordinates, therefore it's important in this command, to have a strong training and education program along with a good officer and enlisted development program." This officer, from one our best hospitals, said a great deal when she made this statement to me. There wasn't a single hospital that I visited that didn't

have a concise and deliberate training program. I'm not just talking about the educational aspect of classroom learning. What was distinctive about our best commands was the fact that they ensured that their personnel were developed through increased responsibility and challenging tasks. Our best hospitals groom their officers and enlisted personnel. "That's exactly what I'm trying to do here" said one Commanding Officer.

> "I demand that all my personnel appropriately staff the work that comes to me. I want them to weigh the impact of the problems and develop alternatives and their costs and benefits. I want things all ironed out before they get to me."

He felt that this type of practice developed his personnel to be better naval officers and managers. "It prepares them for jobs in Washington that they're going to have to face in the future."

Another of the Commanding Officers at our best hospitals went even further. He ensures that all his officers are given the type of tasks that they will need to prepare them for future assignemnts and greater responsibility, regardless of their profession or corps. Judge Advocate General (JAG) investigations are shared between all officers within his command. Various boards and committees are handled in the same manner. If a junior officer feels that the command has a problem, then the Commanding Officer, again regardless of the respective corps, tasks them with researching it and preparing the appropriate staff work on it. "You know, these officers and enlisted personnel must learn to understand that the identification of a problem is not an answer. It's much harder to identify the problem and develop plausible alternatives and implementation strategies." The problem doesn't go away by just telling the Commanding Officer that he has one. There is a lot of pain, frustration, and hard

work in developing an appropriate methodology for resolving it.

Our best hospitals did not rely solely on the training program to ensure that the education process was met. They knew that it took much more then that. I'm not saying that they didn't have good education and training programs, they did. In fact, they were superior to most that I have seen in my fifteen years of service. The key seemed to lie with the fact that the training programs were fully supported within the command. The plans were viewed by our best hospitals as a high-priority activity. Our best commands do not sacrifice training and education of the unit's members in seeking to excel in other areas. They have cohesive plans that are developed with an eye not only on required training, but also the needs of the personnel within the command. Their training plans were well rounded. They included technical/ professional training as well as leadership and management training. Our best hospitals are also aware of our primary mission, contingency for war, and the need for additional training in this particular arena. Two of the three hospitals that I visited didn't ignore this aspect of training within their programs. They made it a point to offer and search out combat-related courses that both their officer and enlisted personnel could make use of.

Training, as one officer stated, "is an on-going day-to-day operation that is the responsibility of every leader within this command." There was indeed a major emphasis on training within our best hospitals. The personnel within these commands were enthusiastic and supportive of the command's training plan. The plans themselves were broad in nature. They covered all aspects, including technical training, military training, leadership and management training, professional on-th-job type training, and of course combat medical training. Training was not focused on

just the junior personnel within these commands, but to all levels. Needs for each professional area and rank structure were assessed and included within the command's training plan. This is what our best had to offer, and if they have their way, they will ensure that there are personnel after them to keep the ball rolling.

H. A BIAS TOWARDS ACTION

This particular indicator is extremely difficult for me to describe. It's important though. It underpins and, when combined with some of the other indicators that I've indicated, makes these hospitals truly our best. I call it the attribute of action orientation. I found this attribut particularly exciting.

It was presnt in two of the three hospitals that I visited, and I don't think I would have found it if some of the other already mentioned attributes had not also been present. Why? For the very same reasons as Peters and Waterman, and Gullickson and Chennette. Action orientation, a bias towards action, evolved in our best hospitals because of a particular leadership style at the top of the organization. As problems and challenges presented themselves, they were passed to experts within the command, that had been discovered, for resolution. Our best hospitals take quick decisive action. The problem isn't bounced around through committees and boards. I saw two Commanding Officers deal exactly this way with potential problems. As they identified a problem, they would call in the appropriate director, tell them the problem, and the date that by which they wanted it resolved. The directorates, and for that matter, everyone within the command, knew that when they were tasked with a project or challenge, it had to be completed within the time frame demanded. As one captain told me, "I'll repeat myself

twice, but not three times." However, what I've been describing is just the results of what our best hospitals have done. How they achieved it is even more interesting and amazing.

## I. ORGANIZATIONAL FLEXIBILITY

Our best commands didn't let the rigid organizational structure bog them down or keep them from being innovative and forward moving. Once again, don't misinterpret this comment. They, just as I, believe strongly in the chain of command. Our best hospitals rely on the chain of command to keep the daily operations of the business of health care and administration running smoothly. But they also recognized that a solid structure without any flexibility can sometimes slow the process of action. Peters and Waterman found the same attribute in their excellent companies. "The concept of organizational fluidity (flexibility), therefore is not new. What is new is that the excellent companies seem to know how to make good use of it. Whether it's their rich ways of communicating informally or their special ways of using adhoc devices... the excellent companies get quick action just because their organizations are fluid (flexible)." As one Commanding Officer said, "I know my personnel and their strengths and weaknesses. If I know of someone within the command that can resolve a troublesome situation quickly, why not utilize that resource? I could use the standard approach and put the problem through numerous committees and other such processes, but the quicker we resolve it (the problem), the quicker we can move on to something else."

At least one of our best hospitals had highly specialized teams who met to identify and solve problems before they developed. Not only did they keep complete files on the

minutes of each meeting, they developed plans of action with milestones, dates of accomplishment, and the tasking of a responsible person to address the problems identified at the meetings. In addition, there seemed to be a sense in the air that these things were discussed openly and candidly throughout the command.

In this same facility, I overheard a discussion between a Chief Petty Officer and a junior officer. The Chief was telling the officer about a situation that he felt could be a potential problem. The officer said, right there and then, "lets go talk to that department head to see if we can work something out." There was the common belief that if someone felt a potential problem about to arise, there would be no problem with going across departmental lines to discuss it. In fact, the department heads said they enjoyed it. "Were not individual departments in this command. Were one command, working together to get the job done. If that means that someone from Operating Management needs to come over to tell me of a problem they perceive, then so be it. Were all better off because of such a policy." There was a strong sense of reliance on the informal communication system within these commands, especially when it came to problem solving. Everyone within the command felt obligated to work together in any way they could to resolve situations and to improve the command. Wherever you walked throughout these commands, you would see task groups brought together, on an informal basis, to discuss and problem solve challenges facing them. Not just intra-department, but across department lines. The executive officer's office, during lunch time, looked like grand central station. He always had two or three personnel in his office who "had just dropped by to chat." But chat it wasn't. A lot of good innovative ideas were thought up and planned during those informal lunch time sessions. When I asked the executive officer how often this

occurred, he said continually. "We take advantage of these informal get-togethers. It gives us alot of information." Remember though, it wasn't that these commands didn't believe in or support the chain of command, quite the opposite. They were wise enough to acknowledge the informal communication channels (the grapevine), and to task teams that spring up natually in any organization.

There is so much literature that points to this phenomenon that I'm surprised that it hasn't surfaced at the other commands I visited. I'm sure that it exists. It just wasn't evident to me that the other commands I visited utilized it to their advantage. In his book Management: Making Organizations Perform, Smith spoke extensively about informal channels of communication and how they can be utilized to an organizations benefit. He felt that the most significant characteristics of the grapevine are its speed, its influence among workers, and its accuracy. In his research on the grapevine, Davis found it to be accurate in anywhere from 75 to 95 percent of the time. Contrary to much that has been written on the subject, the grapevine is not inherently evil. When management makes an effort to keep its' formal channels viable, the function of the grapevine will be to support and reinforce the the formal channels. Our best hospitals, as I have pointed out, know this and use it to their advantage. One of the Commanding Officers continues to be amazed at how well it works. "You know, I am continually astounded by how fast information is passed to the lowest levels in this command."

An example that I found fascinating was the fact that one of the commands I visited was in the middle of a severe budget crunch. The Commanding Officer and Executive Officer had made no formal attempt, through the chain of command, to let the personnel know of the situation. However, they did let the word leak through informal channels. The impact was

tremendous. Everyone I talked to within this command, from the directorate level to the ward corpsmen, were fully aware of the situation and discussed it openly. Even the junior personnel had learned about it and had set about a personal campaign to do what ever they could to save the command money. Lights were turned off when not in use. They had develped the idea of a poor mans night at the mess hall to save the command additional dollars. It was quite evident that the executive leadership of the command had accomplished what they set out to do. Can you imagine what the response to these ideas might have been if they had directed severe restraints from the top leadership through the chain of command?

The key idea here is that our best commands understand the importance of organizational flexibility and use it to their advantage. Communication is only a part of it. It also includes trust in your personnel, and good sound leadership capabilities. With this kind of trust, our best commands didn't get bogged down in the bureaucracy. They took immediate action on items of importance. As one Commanding Officer stated, "We don't sit on our luarels around here. We don't sit around and ponder about problems. We do something, anything. The worst thing that can happen to a command is to not take any action because their researching it or pondering on various alternatives. Our patients and staff want action. They want problems addressed and solved. They don't want to here me say that were currently researching that situation."

## J. STAYING CLOSE TO THE PATIENT

Keeping in touch with your patient's needs, wants, and desires was particularly important in our best hospitals. Does this sound a little familiar? It ought to. It was also

emphasized by our executive leadership in the last chapter. This indicator is somewhat related to the quality assurance programs established within our hospitals. But it goes much further. As one of the Commanding Officers I interviewed stated, "You would be surprised about how much information I can aquire by getting out there and visiting the various commands that we support. Not only do we get some visibility, I can also get some candid information about how well we are meeting their needs. It also gives me an opportunity to market my services and command in a positive sense instead of always having to react to negatives." I found it to be important to these Commanding Officers of our best facilities, to try to understand the climate, environment and culture they operate within. One junior officer told me, "it's not enough to sit over here in our clean, aseptic environment and give the best damn care we can. We have to know our patients. We have to know what they face on a day-by-day basis. We need to know the demands that they face so that we can better do our job of support and service to the fleet and their dependents." Another Chief Petty Officer told me: "I see our job as getting these patients back to their work as fast as possible. That includes dependents. If my wife is sick, I worry about her. That impacts upon my effectiveness."

This particular hospital backed up this statement by the manner in which they managed the hospital and its' various clinics. It was the command's policy that the doctors would come to work early enough to make their ward rounds so that they would be ready to work in their respective clinics by no later then 0745. I haven't seen that type of practice very often in my career. I was amazed when I didn't see patients with 0800 appointments waiting in the clinic until 0900 because the doctor was still making ward rounds. This same policy applied to the various administrative duties.

The patients came first. If that meant that you saw all the patients and then started the administrative duties at 1700, then you started the administrative duties at 1700. Surprisingly, most of the doctors didn't mind this, although some objected strongly. "I had to work long hours during my internship. I didn't expect to have to work like this when I joined the Navy. It's not what they promised me." However, I found this doctor to be the exception, not the rule. How did the Commanding Officer develop this acceptance by the staff? The answer lies within many of the other indicators that I've discussed. The Commanding Officer knew, from his meetings with the consumers of the system, that they were disgusted with having to wait for the doctor as they made their ward rounds. He presented this problem to the doctors who then developed the idea of coming in earlier.

As I stated, our best hospitals made it a point to get out and be seen. The Commanding Officer of one of the hospitals made it a point to have a representation of personnel at the various retirement ceremonies and other special events on the base. They made themselves known through various competition events and other methods of marketing. Yes, marketing. Our best commands put a lot of emphasis onit. Why am I mentioning marketing in a section entitled "Staying Close to the Patient"? The answer is straight forward and simple. In order to market yourself well, you must know the clientele. In addition, in order to know the patients you serve, you must have a good marketing program. After all, isn't a large part of the business that we're in marketing? A concern with those activities which anticipate needs and direct the flow of services to consumers? Our best hospitals perform the marketing function well. They know their patient's wants and desires. They understand the need for finding innovative approaches, given decreasing hospital manpower, to meet the needs of their clientelle. Because of

these things, I found that our best hospitals are highly regarded, not only in the Navy Medical community, but by the community they serve. They spend considerable time and effort in the identification of patient needs, and then in meeting those needs. They stay "Close to the Patient" they serve. Our best commands keep on top of deployment schedules and homeport changes. After all, isn't it better to stay ahead of demand so that you can plan for such events?

I had an officer tell me a long time ago, "Our business is service. Whether it be civilian or government, if we do it well, then we will be successful." The bottom line for civilian companies, as Tomas J. Peters pointed out in a conference I attended [Ref. 13], is not profit. It is providing quality service or products to the people demanding it. "If we do it well," he said, "then profits will take care of themselves." That may be a little over simplified, but the idea is basic. Let's remember what kind of business were in. Our best hospitals do. It was clear that the patients come first. Everything else was oriented around that concept. If we lose sight of that, if we forget the patient, whether it be beneficiary care or contingency for war, then we've forgotten our real reason for existance. If there was one message that our best hospitals were trying to get across, it was that. They do the job well. They strive to meet the needs of their patients despite budget constraints and manpower shortages. The belief of patient first, was a value shared from the Commanding Officers to the newest recruits. These were our best. It was definately a treat to see them in action.

## K. A KEY TO SUCCESS: THE COMMANDING OFFICER

I've already illuded to this particular attribute in many of the other indicators that I've shared with you thus

far. However, it was mentioned so often, that it deserves to be a major indicator itself. The personnel of our best hospitals kept telling me that they were good because of the Commanding Officer. He was the driving force behind their success. In two of the three hospitals, the personnel put the Commanding Officer on a pedestal, while the third, only held the him in high esteem. The Commanding Officer could do no wrong in the eyes of his men and women. It was truely inspiring to see such devotion and loyalty. Most of the personnel I spoke with, including the directors, felt that their Commanding Officer was the best we had to offer. "He is the best Commanding Officer that I've ever had", were typical statements. Other typical comments included such things as; "He cares about us." The officers stated, "I can trust in what he says. If he says it, then you can go to the bank on his words." The chiefs made comments such as; "He trusts us. He has given us the responsibility and respect that a chief petty officer deserves." Not only did the senior enlisted and officer personnel of the command feel this way about the Commanding Officer, but the junior personnel as well. "He gets around and talks to us. He cares about what were doing." A third class petty officer stated, "He expects alot from us, but I don't mind. I'd do anything for him because I know that he'd do everything he could for me." It was interesting, at least to me, to note that most of these Commanding Officer's senior enlisted and junior officers modeled themselves after him. As one junior officer commented, "I have finally found a senior officer that I feel is a powerful, dynamic leader. I've learned alot from him through his own personal examples. I only hope that I will be half as effective as he is when I finally achieve that position."

Only one of the Commanding Officers seemed to be surprised by the way his crew felt about him. The others

seemed to know that they had their personnel's support. However, when I asked them how they went about achieving this type of loyalty, they all seemed to have difficulty verbalizing the "how to" methods. Their comments, in response to the question, included such things as "showing concern for your personnel, expecting high standards, and always striving and pushing them to improve themselves and the command." "It's knowing your crew and getting around and talking to them that seems to make a difference." Another captain stated, "it's setting high standards, although realsitic, and pushing the crew to achieve them; Then crediting them for the effort and making them feel that they are the people that made it all possible."

As another Commanding Officer told me though, "you've got to be sincere when talking to the crew. They can see through an act very quickly. That's the key. I really do care for my command and the personnel that make it effective." One of these same captains told me that caring about and rewarding your personnel is important, but it's just as important to act quickly with any problem children. "They know that I'll go to bat for them. But they also know that I won't tolerate any breech of Navy Regulations." This statement was supported by the junior enlisted personnel who supported the Commanding Officer's beliefs. "There is nothing I like better then to know where I stand. I know what the captain expects, along with my boss, and I also know what will happen if I go U.A. (Unauthorized Absence) or do drugs." Another captain told me; "People are what makes things work. Not law and order or regulations. If people don't want to do it, it is never going to get done. Equally important, if they want to sabotage you, they will. I always define leadership as getting the people to do what I want to do because they want to do it... to me, that's what leadership is... kicking _ss to kissing _ss... whatever it takes."

It was very exciting and refreshing for me, as a junior officer, to see such commands and such powerful, dynamic leadership. But once again, the principles are not new. "I just put into practice what other naval leadership has been doing for years." This comment, by one captain, hit the topic on the head. After returning from my interviews, I broke out some of the old, but still pertinant naval literature, and found exactly what the Commanding Officer was talking about. Don't take me wrong, it's not the average officer who can take these principles and put them to work effectively. But what they had been telling me out there in the hospitals about leadership, has been written down for many years now. Let me share with you some excerpts from some of this literature that the captain was referring to.

The eighth capter of the Naval Orientation Manual [Ref. 14], contains the qualities of a good naval leader. See if any of them sound familiar.

> "Human nature is such that the ordinary person wants to, and will extend loyalty to others in his organization. In the long run however, everyone must earn the right to that loyalty, and part of the price paid for this loyalty is loyalty to others. Enlisted personnel are particularly sensitive about loyalty extended to them and are quick to discern and resent its absence. The degree of loyalty an officer shows toward his personnel has a direct bearing on the morale of his personnel. An officer who has not earned the loyalty of his personnel cannot expect to receive that extra effort above and beyong the call of duty which is so often necessary to accomplish a mission."

These Commanding Officers had that loyalty. As I've illuded to before, their personnel would work 18 hours a day, seven days a week for them. The manual went on to talk about setting a personal example as a characteristic of a good leader.

> "Every young person has a strong personal need for examples to live by, at least until they have formulated their own principles. A naval officer should have such total dignity and competence in all respects that he/she

inspires the enlsited personel to emulate and deeply respect the officer. An officer cannot live by the rule of don't do as I do - do as I say, without the risk of the personnel regarding him with suspicion or distaste."

The Commanding Officers within our best commands set the example. They try to emulate the best that we have to offer for the crew. In return, the crew responds the way that I've described within this section, with loyalty, trust, respect, and hard work. The nice aspect of these commands was the fact these attributes seemed to rub off on the other officers and senior enlisted within the command. While there were exceptions to the rule, in general, most officers and chiefs followed the example set by the Commanding Officer. The importance of this indicator is overwhelming. For without the loyalty and respect of the crews, these commands could not have achieved the results that they have. This was the one aspect that stood out more then any other in making these hospitals the best that we have to offer.

The sheer thrill for myself as a junior officer, to sit and listen to these Commanding officers, was worth all the effort of this project. They were truely strong naval leaders. They had an intensity about themselves and their belief's in command. They knew what it meant to "command". It was interesting to note that each of these Commanding Officers tended to have a "big picture" outlook on the operation of their command. They had control systems established to monitor administrative and clinical matters, but they never got involved in daily operational matters. Those Commanding Officers who were Medical Corps officers, didn't practice medicine. Oh they still got out and talked to inpatient and outpatients alike, but they didn't allow themselves to get involved in micro-management details of day-to-day clinical functions. When asked why, they all had the same type of strong response. "By getting involved in

daily operations, I'm undermining the authority and responsibility of the officers underneath me."

Another attribute that the Commanding Officers of our best hospital's shared was being very tasked oriented. They all shared the view that the mission of the hospital came first. That is, the patients we serve come first. None of them would be satisfied with anything less then outstanding performance by their command. These captains were driven to have the best hospital in the United States Navy. But along the way to the achievement of this goal, they applied good leadership and management practices that instilled within their personnel that they too were the best that we had to offer. Even though the mission came first, the personnel didn't feel that it was at their expense. But rather, it was through them that the mission was accomplished.

## L. EFFICIENCY IS IMPORTANT

Without a doubt, our best hospitals were concerned with efficiency. They always met or exceeded the productivity goals set for them by higher authority. I'm not saying that most of our commands do not meet the productivity goals set for them, but it's important to understand that there appeared to be a difference in how our best hospitals attain them. Their focus was not on increasing the number of patients seen by decreasing the amount of time the patient had with each physician. Rather, it was becoming more efficient with the resources they had available. It wasn't a dictated policy of telling the director of medicine that he had to increase the number of patients seen this next month. It was a team approach, used to determine positive methods of becoming more efficient. At one of the commands visited, they had accomplished this by developing a consensus among the staff that it was necessary for the doctors to make ward

rounds early enough in the morning so that they were ready to begin seeing patients in the clinics by no later then 0745. "It was a simple task of putting the emphasis back on the patients", said one nurse corps officer. "It's not that the administrative duties aren't important, they are. It's just that it's this command's policy that the doctors take care of those types of duties after the patients are seen." Another nurse corps officer told me that through this type of simple policy alone, "productivity has increased tremendously around here." She stated that even before their current Commanding Officer, they were concerned about efficiency and productivity goals. But the way they were met was much different. "The past Commanding Officer would go so far as to walk through the emergency room and order the doctor on duty to admit a patient, just to get the numbers up."

Our best hospitals are more concerned with establishing policies and practices to increase their numbers and efficiency. They arenot so much concerned with the productivity goals, as with finding appropriate methods to set the right type of motivating factors which in themselves, will increase efficiency. As one officer I talked to said, "Anyone can increase the numbers of patients they're seeing in the short-run, but it's the long-run that counts. It's the policies that are set that motivate the staff to be more productive. That is the difference." Our best hospitals function just that way. They were not concerned with short-run methods of increasing productivity. They were more interested in developing a command climate that provides for long-term, lasting efficiency without impacting upon the quality of the care given.

To be honest, certainly some command personnelwere unhappy about some of the policies in this particular command. A few of the medical corps officers didn't feel that it was fair that they had to come into work so early to

make ward rounds. They felt that their independence had been attacked, and thus felt confined. However, as the Commanding Officer of this command stated, as well as a majority of his personnel, "Our primary reason for existance is to take care of these patients. In accomplishing this, my personnel know that they are naval officers first, then nurses, doctors, or administrators second."

I found that the more junior Medical Corps officers had a radical difference of opinion with their captain in this particular area, which also seemed to drive the differences in the scheduling area. They felt that they were professionals first and as such, should be allowed to practice their profession as mature, independent adults. But even they, when confronted by myself, admitted that they prefer the approach by this command over others they had seen, for example, the Commanding Officer ordering admissions.

The trick, as one senior officer stated, "is to establish a policy that motivates our personnel to work efficiently." Our best hospitals would be the first to admit that they haven't found the key yet. But it was apparent that they were on the right track.

## M. DELEGATION: A WAY OF LIFE

Delegation of responsibility, authority and accountability in our best hospitals were indeed a way of life. The commanding officers firmly believed in the principles of delegation, and relied upon it to accomplish their missions. They were not "micro-managers" in the sense that they wanted to keep their hands in everything. They trusted their personnel and in their abilities. I'm not saying that they advocated their responsibility of command, quite the oppisite. These commanding officers knew what "command" meant and their personnel knew who was in command.

Our best hospital's commanding officers felt, just as our executive leadership, that they owed it to their personnel and command to push responsibility as far down the chain of command as possible. One of the commanding officers I spoke with told me, "I just give the direction of the command. That is, I set the climate. I pass the problems down and expect them to do the problem solving." He felt that this accomplished two important things within his command. First, it gave his personnel the chance to develop their leadership skills and problem solving skills. It gave them the opportunity to learn what staff work was all about. Secondly, it gave his personnel the feeling that they had a part in the decision making process within the command. They felt challenged. One first class petty officer told me this about his command. "This is the first command that I've been at that really gave me an opportunity to be a real petty officer. I have personnel that I'm in charge of and totally responsible for. I like that."

The key within these, our best hospitals, seemed to be the fact that along with the delegation of responsibility, they ensured that the necessary authority and accountability was also delegated. People were given the amount of authority needed to do the job assigned. They were also held accountable for the completion of the tasks. When people were given a project or task, they knew that they had better have it done on time and to the commanding officer's standards, regardless of profession, corps, or rank. As one commanding officer stated, "I don't ask twice for things." But the officers of these commands were also quick to note that the Commanding Officers were quite fair about how much responsibility was given to people. "It is an educational process," said one executive officer. "We delegate only that amount of responsibility we think a person can reasonably handle. Just enough to stretch them a little."

So far, I've spoken mostly of the officer's community. However, this principle went much further than that in our best commands. It was practiced and preached at all levels. But the key to success started with the commanding officer and executive officer who set the climate and the example to follow. They are the individuals who set the process into action and demand their subordinates to do the same. "It is the one aspect of this command" says one executive officer, "that brings us together as a team and allows us to operate as efficiently as we do. It's the key to effective leadership." As one senior officer told me; "A successful leader is one who can leave his work center or command and never be missed. The personnel can carry on just as well, if not better, then when your there. If you've accomplished that, then in my book, you have been a success."

## N. THE CHIEF PETTY OFFICER

The Chief Petty Officers were a resource that our best hospitals recognized and used. They were given the responsibility commensurate with the title of "chief". Our best commands relied upon the chief to not only lead and manage the junior enlisted personnel, but the junior officers as well. It was the chief's responsibility to take these inexperienced junior officers within the command, and educate them on the principles of leadership. From what I saw, they had accomplished that task well. The question that I had was how these commands were making this happen? Two of the three commanding officers, through their Master Chief Petty Officer of the Command, ensured that the chiefs knew exactly what was expected of them from the minute they reported aboard. Upon reporting, they were told what the command's view of a chief petty officer was, and that they were expected to conform to that role. There wasn't a chief that

I talked to that took exception to the role given to them. Our best hospitals feel that the chief petty officer's role was to get the job done through people. To act as a model for the junior enlisted members of the command. To discipline when necessary and to ensure the maintenance of military standards of all enlisted personnel. But above all else, it was the chief petty officer's job to take care of his personnel. To educate, train and develop them. To ensure that they receive the word. This however, is no easy task. As one chief told me, "it often means hard work, ingenuity, and long hours. But as a chief petty officer who is responsible for his personnel, and to lead his personnel, that is quite often what it takes." There was no doubt that the chief's community was active at our best hospitals. Their position, throughout naval history, has demanded these very attributes that have been discussed, for which they have always come through. This was no different at our best commands.

## O. FIELD INTERVIEW SUMMARY

There you have it. The story of the best that we in Navy Medicine have to offer. While I may have forgotten something, I think that I have described, accurately paints a picture of what I saw. The results were truly inspiring, especially for a junior officer.

As I have already stated in this chapter, not all the fifteen indicators were present at each of the commands visited. However, two of the three came very close to having all fifteen. That may explain why our executive leadership had difficulty in identifying one truly excellent command. Table II shows a breakdown of the three hospitals visited and the indicators present in each.

TABLE II

Indicators by Command

| HOSPITAL INDICATOR | HOSPITAL "A" | HOSPITAL "B" | HOSPITAL "C" |
|---|---|---|---|
| THE CAPTAIN IS OUT AND ABOUT | HIGH | LOW | HIGH |
| THE BEST DARN LITTLE HOSPITAL IN THE USN | HIGH | LOW | MED |
| TEAMWORK | HIGH | MED | HIGH |
| A FOCUS ON WHAT'S IMPORTANT | HIGH | MED | HIGH |
| NOT ONLY ARE THEY GOOD, THEY LOOK GOOD | MED | LOW | HIGH |
| DEVELOPMENT OF THE FUTURE | HIGH | LOW | MED |
| A BIAS TOWARDS ACTION | HIGH | MED | HIGH |
| ORGANIZATIONAL FLEXIBILITY | HIGH | MED | MED |
| STAYING CLOSE TO THE PATIENT | HIGH | LOW | HIGH |
| A KEY TO SUCCESS: THE COMMANDING OFFICER | HIGH | LOW | HIGH |
| EFFICIENCY IS IMPORATANT | MED | HIGH | HIGH |
| DELEGATION: A WAY OF LIFE | HIGH | LOW | HIGH |
| THE CHIEF PETTY OFFICER | HIGH | MED | MED |

It is difficult to prioritize these indicators, or give the reader an idea of which are most important. Possibly with additional study and evaluation this could be accomplished, but I doubt it. Why? I think for the same reasons that I shared with you about the executive leadership's views on excellence. All these indicators co-exist and support each other. Take away two or three, and you may only have an average command. Or for that matter, remove two or three and you may have a sub-average command. Despite this, I can make this comment: It seemed to me that all indicators point directly to the top of the organization. Without a strong leader, excellence just won't happen.

So what are the implications of these findings? What good was this study? I think it has powerful implications and can offer much to the Navy Medical Department. For that matter, It may have some applicability to other Medical Departments within the Department of Defense. My final chapter will discuss these implications and the potential usefulness of this study in some detail. So please read on. I've not finished yet.

## V. CONCLUSIONS AND RECOMMENDATIONS

Now that I've taken you through the passageways and offices of our executive leadership and into the commands they felt were our best, let's take a closer look at what these findings may indicate. First though, let me say that there is a lot to be learned from the views of our senior medical department officers. A statement of the obvious? Maybe, but as I've said many times within this thesis, these views are not known to many, especially our junior officers. That statement alone indicates the potential usefulness of this study. It may prove useful to let personnel within the medical department become aware of those aspects of command that our senior officers feel would be present in an excellent hospital. It serves no meaningful purpose to withhold these views. In fact, it can lead to confusion and crisis management situations. I've got to know where I'm heading, and more importantly, where the organization is heading, if I'm going to be expected to assist in attaining the bullseye that we're aiming for.

When I was out in the field talking to our best commands, it was obvious to me that their top leadership, at least in two of the three hospitals, knew exactly what they wanted for their commands. However, it was also very clear that this was not based on guidance from above, but rather was based on their own beliefs about what excellence should look like. As I pointed out in Chapter Three, the difficulty of creating a common vision may stem from the top of our organization. Don't take me wrong. Our senior officers are superb leaders and managers. The problem I'm referring to is the fact that there was often different views and sometimes strong disagreement between our executive leadership about

what an excellent hospital would look like. This disagreement seemed to stem from a difference in belief between our respective corps, each steeped with their own values and traditions. For example, one of our senior Medical Corps officers made the comment that the Commanding Officer of an excellent hospital would still be taking care of a limited number of patients if he was a Medical Corps officer. A senior Medical Service Corps and a Nurse Corps officer, believed strongly that a Commanding Officer should be managing the hospital, not seeing patients. Other senior officers felt we should be putting more emphasis on providing the best quality of medical care that we can, while some felt that this also must be done as efficiently and cost effective as possible. These are just a few of the examples. The point, at least to this author, is that as I walked away from our executive leadership and the three commands that I visited, I had a strong feeling that we actually have two organizations within one: The physicians, concerned with providing the best quality of care possible, and the administrators, concerned with accomplishing medical care as cost effective as possible. Although I'm not telling you anything which hasn't been discussed before, both within Navy medicine and the civilian sector, the question remains, what can be done about it?

As I mentioned earlier, the key, in at least two of the three hospitals I visited, seemed to lie with the Commanding Officers. They drove the command. They set the mood and the values within the command. They were participative managers who expected results. They stated "what" needed to be done, but were careful to avoid telling their personnel "how" to accomplish the tasks. If you took away these two Commanding Officers, and put autocratic leaders in their place, then I don't think the commands would continue to perform at a high level of effectiveness. Our senior leadership have also

recognized the importance of the Commanding Officer billet, and the impact it can have on a command. In recognition of this, they have recently developed the new 2XXX designator. This new 2XXX designator should aid in selecting the leadership that we feel is needed to lead and manage the Navy hospitals of the future. This thesis can aid in identifying those abilities needed by perspective Commanding Officers from which selection can be made. It can also provide the impetus for training and developing our officer community as they progress in their career.

More importantly though, if what our senior officers would like to achieve in all our commands is excellence, as they have described it, then we first must develop a shared vision of excellence that together, we can strive towards. This study can aid in that process. It can be the fountainhead from which this vision can spring to life. But, you may ask, is a shared vision really needed? Well, why don't I leave that for you to decide. However, before making that decision, take another look at Table III and the findings reported in Chapter Three dealing with the views of our executive leadership. Also, let me remind you that none of the three hospitals scored high on all attributes identified. Does this mean that we don't truly have an excellent hospital out there? That's what most of our senior officers felt. After visiting our "best", I would agree, at least tentatively. However, further research should be conducted on other commands to validate these results. I can say, without any reservation, that Hospital "A" and "C" were the closest to excellence that I have witnessed in my fifteen year career. But what about hospital "B", is it really our third best hospital? According to our leadership it was. But let's not be too quick to pass judgement. It was doing many things well, it just wasn't doing them as well as the other two commands I visited. But if this is truly our third best

facility, the question then comes up; what do the rest of the Navy's hospitals look like, and why the great disparity? That question may lead us back to why a vision of excellence is needed. Both Hospital "A" and "C" knew exactly what they wanted to accomplish, and they had leaders with exceptional abilities guiding them towards that end-result. Hospital "C" seemed to be operating on a day-to-day basis, reacting rather then being pro-active. It seems to this author that a clear direction and vision of excellence from which to chart our course, would allow our commands a better opportunity to achieve the excellence that we all may strive for. It also follows that if this vision of excellence can be used as a yard stick, then we will also have a standard from which to measure our success.

Maybe another question is lingering in the back of your mind. These findings may be all very interesting, but what about the methodology of the study? Would such an approach provide valid and useful findings? I believe that it would. The use of interviews and direct observations provided me, and hopefully you, with a rich, full picture of excellence within naval health care. The findings paralled the findings of the McBer and Company study on Excellence in Navy Medical Department Leadership and Management which was completed in February, 1984 [Ref. 15]. I was lucky enough to meet with McBer and representatives upon completion of this project to compare our respective findings. Not surprisingly, our results were very simular. Other students at the Naval Postgraduate School who have conducted similar studies of excellence in other areas of the Navy and Department of Defense, have found simular attributes common to excellent organizations. Despite this, further validation may be useful by gathering more information from a larger section of senior officers and hospitals.

If our senior leadership feels that this study may be helpful, then how do we develop this vision of excellence? I think the key will be in the development of a vision that is mutually agreed upon and supported by all of our senior officers. In addition to this, an awareness of this vision by all members of the Navy Medical Department is just as important. In the following paragraphs, I have attempted to outline some alternatives that, when taken together, should assist us in arriving at that desired end-result.

This study and the McBer and Company studies, could be used as a starting point to gather the key senior officers of Navy medicine around in order to further clarify excellence in Navy health care. It is this author's opinion that any organization, without a common vision of what they are attempting to achieve, will have difficulty in meeting the desired ends. The old saying, "if I don't know where my boss is going, it's hard for me to help him get there", can apply in any organization. This study can provide that initial guidance to our hospital commands on what excellence may look like.

Once a consensus has been reached between our key senior officers, then their results can be distributed through a variety of methods. Some could include the quarterly Commander's Conferences, Navy Medicine articles, and through meetings with the various Geographical Commanders. Perhaps the greatest potential for this study would be its inclusion into the newly developed Leadership and Management Education and Training (LMET) program developed by McBer and Company. In addition to covering the competencies of effective leaders, this study could show what can happen within a command if those competencies are performed well. It can also begin to develop some standards of leadership that are expected across professions and corps. In addition to being a doctor, nurse, or administrator, we are all naval leaders

first, who should develop certain competencies in order to be effective as such. Leadership is not just a science, but it's also an art. We must learn that art with the discipline of those great leaders who came before us.

Another possibilitiy for this study, which could aid in the development of a common vision, could include its addition into the perspective Commanding Officer and Executive Officer course, and as additional reading material for newly commissioned officers of the Navy Medical Department. This approach would ensure an awareness of excellence by all perspective Commanding Officers before they assume command. It would also begin to develop an understanding between each corps within Navy medicine on what excellence may look like.

Finally, it may prove quite useful to take advantage of the resources the Navy has to offer us. During my research for this study, I became increasingly aware of those resources that we have available to improve our performance, effectiveness, and efficiency. Most importantly, these resources are available to assist us in developing this vision of excellence that I've described to you. First, there are the Navy's Organizational Effectiveness Centers, distributed throughout the world. These commands will provide trained Organization Development consultants to assist the Naval Medical Command in the process of further defining this vision of excellence and then with methods for its implementation. These individuals are highly skilled consultants and managers who can also aid individual commands improve their efficiency, effectiveness, and management expertise. They are a talent that we in the Naval Medical Department can make good use of. Second, within our own medical community, we have at our disposal at least five Organization Development trained consultants, some with up to five years experience in the field, who can also be used to our benefit. How? With the development of a Naval

Medical Department Organization Development unit, these individuals could assist not only Naval Medical Command, but individual hospitals as well, with the development and implementation strategy for this vision of excellence. As members of the "health care team", they will have already developed some amount of creditability within Navy medicine, and are fully aware of the unique challenges that we face. They could be further used by individual commands to assist in most any type of problem we may encounter. This "cell" of expertise could be continued by maintaining current quotas in the Organization Development curriculum at the Naval Postgraduate School. The field of Organization Development is relatively new in the health care system, both civilian and military, and currently growing in demand. We too could capitalize on this talent to assist us in achieving the excellence we strive for. Last but not least, as I visited our "best" hospitals, it was obvious that they felt a significant need for leadership and management training for all echelons within their commands. They had taken advantage of the Navy's Leadership and Management Education and Training program for their enlisted personnel. While the Naval Medical Command's program is beginning, we should continue to search out quotas for others to attend. In combination, it is my belief that these resources could readily assist in developing our vision of excellence and its subsequent attainment.

These are exciting times for us in Navy medicine. We've accomplished much in the last two years. But, there is much more that we can achieve. A vision of excellence can help us to reach further. It can bring us closer together, all corps, marching in one determined direction. The personnel in our hospitals that I talked to, all agreed that this common vision is needed. But what about our primary mission, contingency for war? For some reason, it was absent

within this study. Shouldn't a study, such as this, be conducted in view of our primary mission? I couldn't agree more. Such a study should be accomplished. But for now, we have a foundation from which to build.

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